Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 000 | Initial Comments<br><br>The Adult Care Licensure conducted a follow-up survey and complaint investigation on 09/04/24 through 09/06/24. The Edgecombe County Department of Social Services initiated the complaint on 08/28/24. | C 000 | | |
| C 141 | 10A NCAC 13G .0406 (a)(1) Other Staff Qualification<br><br>10A NCAC 13G .0406 Other Staff Qualifications<br>(a) Each staff person of a family care home shall:<br>(1) have a job description that reflects actual duties and responsibilities and is signed by the administrator and the employee;<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure a job description that reflects actual duties and responsibilities was signed by the Administrator and the employee for 1 of 2 sampled staff (Staff B).<br><br>The findings are: | C 141 | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 141 | Continued From page 1 | C 141 | | |

Review of Staff B's personal record revealed:
-There was a signed job description as a personal care aide (PCA)/"key holder" with a hire date of 04/10/24.
-There was no signed job description for Supervisor-In-Charge.

Interview with the SIC on 09/06/24 at 8:11am revealed:
-She was not the SIC but was working on the training little by little.
-She was the only staff when she stayed overnight at the facility with the residents.

Second interview with the SIC on 09/06/24 at 4:16pm revealed:
-She began working at the facility in July 2024.
-The Administrator spoke with her in August 2024 about becoming the SIC and she began training at that time.
-She was learning to make notifications to providers and write notes.
-She had not signed a job description for SIC with the Administrator.

Interview with the Administrator on 09/04/24 at 2:45pm revealed:
-Staff B was "acting as" SIC because she lived across the street from the facility.
-Staff B was still in training for SIC and training was based on the Administrator's old job description from when she was an SIC.
-Staff B was not following procedures per the Administrator's standards of operation but she knew the basics.
-Staff B continued to be trained by her while the Administrator was attempting to hire a permanent SIC.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **FCL033016** | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 141 | Continued From page 2<br>Second interview with the Administrator on 09/06/24 at 3:22pm revealed:<br>-Staff B was a personal care aide (PCA) and temporary SIC and was still in training for the SIC position.<br>-There was no SIC job description for Staff B.<br>-She did not know a job description should be signed by her and Staff B and maintained in the personal file. | C 141 | | |
| C 187 | 10A NCAC 13G .0601 (e)(f) Management And Other Staff<br><br>10A NCAC 13G .0601 Management And Other Staff<br><br>(e) At all times the administrator or supervisor-in-charge shall be in the facility or within 500 feet of the facility with a means of two-way telecommunication. The administrator or supervisor-in-charge is directly responsible for assuring that all required duties are carried out in the facility and for assuring that at no time is a resident left alone in the facility without a staff member.<br>(f) When the administrator or supervisor-in-charge are not in the facility or within 500 feet of the facility, a staff person who meets the staff qualification requirements of this Subchapter shall be on duty in the facility. The staff person shall be on duty in the facility no more than eight hours per 24 hours and no more than 24 hours total per week. | C 187 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 187 | Continued From page 3 | C 187 | | |

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the Administrator failed to ensure at all times there was a staff member on duty and present in the facility to supervise residents.

The findings are:

Review of Services Offered in an undated facility handbook revealed the facility would provide residents with twenty-four-hour supervision by compassionate and trained staff.

Observation of the facility on 09/04/24 at 8:10am revealed the Administrator arrived and unlocked the front door to the facility.

Review of Resident #3's current FL-2 dated 09/21/23 revealed:
-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, borderline intellectual functioning, and hearing loss.
-The resident was ambulatory and constantly disoriented.
-The resident wandered and was verbally abusive.
-The resident's recommended level of care was family care home.

Review of Resident #3's current care plan dated 10/03/23 revealed:
-The resident wandered and was verbally abusive.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required limited assistance with eating, toileting, bathing, dressing, and grooming.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 187 | Continued From page 4<br><br>Interview with the Administrator on 09/04/24 at 8:15am revealed:<br>-Resident #3 walked out of the facility earlier this morning because he was "mad."<br>-The resident reported he was "mad" because another resident took his cigarettes.<br>-The resident missed the bus that provided transportation to a Psychosocial Rehabilitation Program (PSR) earlier this morning because he left the facility.<br>-She did not know where Resident #3 was, he usually walked to different businesses in the community.<br>-She left the facility earlier this morning and locked the facility.<br><br>Second interview with the Administrator on 09/04/24 at 9:19am revealed:<br>-She had to leave the facility to transport a nonresident to a medical appointment and locked the facility.<br>-She was not aware of where Resident #3 was located; he had not returned to the facility.<br>-She looked for Resident #3 when she arrived at the facility at 8:10am because she did not have time.<br>-The SIC who lived across the street had cameras and was responsible for letting Resident #3 back in the facility when he returned.<br><br>Observation of Resident #3 on 09/04/24 from 9:26am to 9:37am revealed:<br>-Resident #3 walked up the street to the driveway of the facility.<br>-The resident talked in a loud voice, looking up and down the street, and walked into a neighbor's yard.<br>-The resident continued to talk to himself loudly while smoking a cigarette. | C 187 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 187 | Continued From page 5 | C 187 | | |

-The resident paced a few steps up and down the street from the curb of the street to the middle of the street.
-The resident walked onto the sidewalk in front of the facility when two cars drove down the street.
-The resident walked up to the van in the facility driveway and nodded his head several times as he walked around the van back to the street.
-The resident sat on the front steps of the facility and then returned to the street in front of the facility.
-The SIC, who lived across the street, walked to the facility at 9:37am, spoke to Resident #3, unlocked the facility and walked into the facility with Resident #3.

Observation of Resident #3 and the SIC on 09/04/24 at 9:51am revealed the SIC and Resident #3 left the facility on a facility van and the SIC returned to the facility without Resident #3 at 10:30am.

Interview with Resident #3 on 09/06/24 at 8:00am revealed:
-His psychiatrist approved for him to have 2 hours of unsupervised time in the community.
-He enjoyed walking to visit friends at local stores in the community.
-There were a few times he walked back to the facility and the door was locked; so, he waited on the front porch steps for someone to come let him in the facility.

Interview with the SIC on 09/04/24 at 10:30am revealed:
-She was currently off duty, and the Administrator had not given her any instructions regarding what to do when Resident #3 returned to the facility or did not return to the facility that morning when he left.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 187 | Continued From page 6<br>-She had cameras at her house and happened to see that Resident #3 had returned to the facility.<br>-The facility was locked when Resident #3 returned to the facility, so she called the Administrator, and the Administrator instructed her to meet her with Resident #3 so he could be with her. | C 187 | | |
| C 243 | 10A NCAC 13G .0901(b) Personal Care and Supervision<br><br>10A NCAC 13G .0901 Personal Care And Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A1 VIOLATION<br><br>Based on these findings, the previous Type A1 Violation was not abated.<br><br>Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 4 residents (#3) who was assessed as being constantly disoriented, wandered around town unsupervised, and eloped to a town that was over one hour from the facility.<br><br>The findings are:<br><br>Review of the facility's undated Identification and Supervision of Wandering Residents policy revealed:<br>-The facility would identify residents who developed disorientation and wandering behaviors and keep them safe until a secured environment could be obtained for the resident. | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ____ B. WING ____ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 7<br>-When a cognitively impaired resident began to wander, staff should provide a secure boundary or perimeter to safely accommodate the resident.<br>-Staff would be trained on the importance of preventing unsafe wandering and supervision would be provided to meet the identified needs of the resident.<br>-The Administrator, Supervisor-in- Charge (SIC), and staff should observe the location of each resident at risk for elopement with ongoing communication between staff if necessary to transfer information related to the presence of behaviors that indicate elopement is likely.<br><br>Review of Services Offered in an undated facility handbook revealed:<br>-The facility would provide residents with twenty-four hour supervision by compassionate and trained staff.<br>-The facility would provide immediate response in case of an emergency, accident, or incident involving a resident.<br><br>Review of Resident #3's current FL-2 dated 09/21/23 revealed:<br>-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, borderline intellectual functioning, and hearing loss.<br>-The resident was ambulatory and constantly disoriented.<br>-The resident wandered and was verbally abusive.<br>-The resident's recommended level of care was family care home.<br><br>Review of Resident #3's current care plan dated 10/03/23 revealed:<br>-The resident wandering behaviors and was verbally abusive. | C 243 | | |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 8<br>-The resident was sometimes disoriented, forgetful and needed reminders.<br>-The resident required limited assistance with eating, toileting, bathing, dressing, and grooming.<br><br>Review of Resident #3's Independent Assessment for Personal Care completed by a home health (HH) agency dated 06/19/24 revealed:<br>-The assessment was completed by a home health (HH) agency.<br>-The resident required extensive assistance with bathing and personal care.<br>-The resident was cognitively unable to demonstrate to the assessor how to transfer into the shower without verbal prompting.<br>-Per the Administrator's report, staff had to hold onto the resident to assist him with getting in and out of the shower due to his cognition and lack of balance.<br>-The resident required extensive assistance with dressing with clothing, socks and shoes and removing clothing, socks, and shoes.<br>-The resident was cognitively unable to put on his underwear and pants or pull up his pants to his waist.<br>-The resident required set up and supervision for ambulation from room to room in the facility.<br>-The resident was observed occasionally unsteady but able to steady himself without assistance.<br>-The Administrator reported to the assessor that Resident #3 wandered at times.<br>-Resident #3 was able to verbalize his name but unable to verbalize his date of birth, current location, month or year.<br><br>Review of a progress note completed by the Administrator dated 08/12/24 at 7:00pm revealed the Administrator documented that staff was in | C 243 | | |

C 243 Continued From page 9 C 243

the kitchen, and when they came back into the family room Resident #3 cut off the door alarm and walked out of the facility.

Review of the facility sign in/out log revealed:
-The facility sign in/out log had six columns to be completed with the date, time out of facility, time returned to facility, resident's signature, and staff signature.
-There was no documentation on the facility sign in/out log that the resident left the facility on 08/12/24 at 7:00pm and there was no return time documented.

Review of a progress note completed by the Administrator dated 08/13/24 at 7:30am revealed:
-Resident #3 was in the kitchen and the Administrator observed the resident cut off the door alarm at the kitchen door and attempted to leave the facility.
-There was no documentation of whether the resident left the facility.

Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 08/13/24, there was no time of when he left, and no time of return.

Review of a progress note completed by a personal care aide (PCA) on 08/18/24 revealed:
-There was a time listed of 8:58; am or pm was not indicated.
-Resident #3 ran out of the facility on weekend staff and the resident was instructed to return.
-There was no documentation when the resident returned to the facility.

Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 08/18/24, there was no time of when he left, no time of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 10 | C 243 | | |

return, and no staff signature.

Review of a progress note completed by the Administrator dated 08/21/24 at 8:30pm revealed:
-She told Resident #3 at 8:30pm that he needed to return the facility in 15 to 30 minutes or else staff would call law enforcement.
-She documented the resident responded, "okay."
-She spoke with the SIC at 9:15pm and the SIC reported the resident had been walking in and out of the facility.
-She instructed the SIC to contact law enforcement if the resident had not returned in 15 to 30 minutes.

Review of a progress note completed by the Administrator dated 08/22/24 at 7:30am revealed:
-When she arrived at the facility at 7:30am, law enforcement was present.
-She questioned the SIC about why law enforcement was at the facility and was told Resident #3 had not returned to the facility last night (08/21/24).
-She asked the SIC why she did not call her back last night or called law enforcement when the resident had not returned.
-There was no documentation of the SIC's response to the Administrator.

Review of an Incident Report dated 08/23/24 revealed:
-The date of the incident was 08/22/24 at 6:15am.
-The incident type was a missing person.
-The missing person was identified as Resident #3.
-Local law enforcement was called due to Resident #3 not returning to the facility in a timely manner; there was no date or time documented.
-Staff made a missing person's report; there was no date or time documented.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 11 | C 243 | | |

-The Administrator notified Resident #3's guardian and psychiatrist.
-Resident #3 was found; there was no date or time documented.
-Follow-up actions included extra precautions to protect the resident's safety, an appointment was made with the resident's psychiatrist and an order was obtained from Resident #3's psychiatrist was obtained for his safety.

Interview with a Supervisor-In-Charge (SIC) on 09/06/24 at 4:16pm revealed:
-She did not know what time Resident #3 left the facility on 08/21/24 because he had already left the facility when she arrived to work at 7:00pm.
-She sent a text to the Administrator at approximately 11:00pm when he had not returned, and the Administrator instructed her to call local law enforcement if he did not return in an hour.
-It was not unusual for Resident #3 to go in and out of the facility and would sometimes sit on the porch until approximately 4:00am.
-She checked the porch through the night but Resident #3 did not return to the facility.
-She did not call the local law enforcement until the next morning because they got mad due to the facility calling them often regarding Resident #3 walking out.
-She thought Resident #3 would return to the facility because he always returned.
-She did not call or text the Administrator after 11:00pm on 08/21/24 and the Administrator did not call or text to see if Resident #3 had returned during the night.
Review of a communications Event Report from local law enforcement dated 08/22/24 revealed:
-The call was received on 08/22/24 at 6:41am.
-The nature of the event was a "Missing/Found Person."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 12<br>-Resident #3 was last seen by the Administrator at approximately 8:00pm the previous evening on 08/21/24.<br>-Resident #3 was walking in an area approximately 2 blocks from the facility when the Administrator stopped to instruct him to go back to the facility to take his medications.<br>-It was reported by staff that Resident #3 did not return to the facility throughout the night.<br><br>Interview with the Administrator on 09/04/24 at 2:45pm revealed:<br>-She left the facility at approximately 8:30pm on 08/21/24.<br>-She was in her car in the driveway of the facility when she told Resident #3 to go into the facility within 15 to 30 minutes or local law enforcement would be called; Resident #3 was outside the facility at the curb smoking a cigarette at that time.<br>-She spoke with the SIC on duty via phone at 9:15pm and told her to call local law enforcement if he did not return within the hour.<br>-When she arrived to work just after 7:00am on 08/22/24, local law enforcement was at the facility.<br>-She was not notified by the SIC prior to her arrival that Resident #3 did not return to the facility all night and that staff had not called local law enforcement until the morning of 08/22/24.<br>-Resident #3's legal guardian was notified on 08/22/24 of the elopement, Resident #3 was found in another town with a family member around 10:00pm on 08/22/24, and he was returned to the facility after midnight on 08/23/24.<br>-She thought the resident hitchhiked to visit a family member.<br>-Resident #3 received an order from his psychiatrist for 2 hours of unsupervised leave on 08/27/24 but did not have an order for any | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 13<br>unsupervised leave at the time of the elopement.<br>-She spoke with Resident #3's guardian on 08/23/24 and agreed Resident #3 would need 24 hour supervision from facility staff except when he attended his PSR program.<br>-She spoke with Resident #3's guardian again on 08/28/24 or 08/29/24 about the 2 hour unsupervised leave order that was written by the resident's psychiatrist.<br>-Resident #3's legal guardian told her to go with provider's recommendations with no protest, voiced concerns or instructions given.<br><br>Interview with Resident #3 on 09/05/24 at 8:00am revealed:<br>-He walked away from the facility to a local business and obtained a ride to visit his family.<br>-He was upset with the Administrator because she talked "ugly" to him.<br>-He was almost back to the facility after he had walked in the community and the Administrator told him he needed to return to the facility.<br>-The Administrator told him, "I'm gonna get the men in this home to beat you up, if they can't do it, I'll get my husband to knock you out."<br>-The Administrator threatened to put him in a "home" if he did not listen to her.<br>-He was scared to go to a "home" because he did not know how he would be treated.<br>-Resident #3 reported he cursed at the Administrator and left the facility.<br>-He went to a local business owner if he could provide him with a ride to his family because he was afraid the Administrator would place him in a "home."<br><br>Interview with Resident #3's legal guardian with a Department of Social Services (DSS) on 09/04/24 at 9:45am revealed:<br>-Resident #3 called her from a local business on | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______<br>B. WING ______ | R-C<br>**09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE<br>ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 14<br>08/21/24 and left her a voicemail that he had been kicked out of the facility because he did not go to a day treatment program.<br>-She was informed by the Administrator of the facility on 08/22/24 that the resident was missing and had left the facility on the evening of 08/21/24.<br>-She contacted local law enforcement where the facility was located to report the resident as a missing person on 08/22/24.<br>-She also contacted local law enforcement where his family member lived to file a missing person report.<br>-She called the local business near the facility because the resident called her often from that location.<br>-The owner of the local business reported that Resident #3 came to his business on 08/21/24 upset that he had been kicked out of the facility.<br>-The resident wanted a ride to a family member who was located approximately 66 miles away from the facility.<br>-The business owner provided a ride to Resident #3 to his family members location and left the resident with his family member.<br>-Her agency received a telephone call from local law enforcement at 10:00pm on 08/22/24 that the resident had been located with his family member located in another town, which was 66 miles away.<br>-She notified the Administrator that Resident #3 had been located and staff with DSS would be driving him back to the facility on 08/22/24 so the Administrator could notify local law enforcement near the facility the resident had been found at 10:00pm.<br>-Staff with DSS provided the resident transportation back to the facility on 08/22/24 and he arrived back at the facility at approximately 12:00am on 08/23/24. | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 15<br>-She spoke with the Administrator of the facility on 08/22/24 and 08/23/24 to inform her that Resident #3 required constant supervision due to his mental health crisis.<br>-She explained to the Administrator several times that under no circumstances should the resident be without supervision.<br>-The Administrator informed her that staff at the facility were unable to provide the resident with constant supervision because he walked out, and they could not force the resident to stay at the home.<br>-The legal guardian reinforced with the Administrator that she had to ensure Resident #3 had constant supervision due to his mental health crisis.<br>-The Administrator informed her that Resident #3 had an upcoming appointment with his psychiatrist, and she would request 2 hours of unsupervised time for the resident because he was frustrated that he did not have any time that was unsupervised.<br>-She spoke with the Administrator via telephone on 08/23/24 to obtain an update on Resident #3, the Administrator informed her that the resident's psychiatrist had written an order that the resident could have 2 hours of unsupervised time.<br>-The legal guardian again explained to the Administrator that Resident #3 continued to require constant supervision to ensure his safety due to his elopement and mental health crisis.<br>-The Administrator asked her if she agreed to the resident having 2 hours of unsupervised time and the guardian verbalized that she did not agree to any unsupervised time for Resident #3.<br>-She explained to the Administrator that Resident #3 had never eloped before and this was a mental health crisis for him; he was unhappy at the facility, and did not want to be there, so the resident had to be supervised at all times to | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 16 | C 243 | | |

ensure his safety.

Interview with the owner of the identified local business on 09/04/24 at 5:18pm revealed:
-Resident #3 came to his business every day.
-The resident usually called his family member when he visited.
-The resident came to his business on 08/21/24 late in the afternoon and reported he had been kicked out of the facility.
-The resident was upset, agitated and angry.
-The resident asked if he would transport him to visit his family.
-He left the shop and transported Resident #3 on 08/21/24 at 5:30pm.
-It took approximately one hour and 10 minutes to arrive at Resident #3's family members location.

Review of mapquest.com on 09/06/24 revealed:
-The local business was located on a five-lane highway.
-The estimated distance from the facility to the local business was 0.3 miles.
-The average time of walking distance from the facility to the local business was 7 minutes.
-To walk from the facility to the local shop Resident #3 would cross 3 residential intersections of two-lane streets
-The major intersection had traffic that traveled four different ways.
-The speed limit on the two five lane highways was 35 miles per hour (mph).

Telephone interview with Resident #3's family member on 09/05/24 at 1:40pm revealed:
-The resident's friend drove him to visit family.
-The resident reported that he had been kicked out of the facility and did not want to live there anymore.
-The resident was frustrated, angry and agitated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 17 | C 243 | | |

at the Administrator of the facility because she threatened to send him to another facility.
-She was happy to see the resident and the resident enjoyed visiting his family.

Interview with the Director of a PSR program that Resident #3 attended on 09/04/24 at 11:20am revealed:
-Resident #3 had auditory hallucinations and would have a full conversation with himself that others could hear.
-The resident would "fuss" more at the voices he heard and shared with others that he wanted to go home.
-The resident was easily redirected when he became agitated from auditory hallucinations.
-All residents at the PSR program were provided with constant supervision.
-Resident #3 was absent from the PSR program on 08/21/24 and 08/22/24.

Second interview with the Administrator on 09/04/24 at 3:15pm revealed:
-She asked Resident #3's legal guardian on 08/23/24 what she recommended to ensure the resident's safety.
-She reported that the legal guardian directed her to follow the resident's psychiatrist orders and did not recommend the resident to be placed under constant supervision.
-She had no concerns for the resident's safety because he was not a threat, everyone knew him and people called the facility when they saw him walking in the community.
-The Administrator reported that it was not safe for any of the resident's to be out of the facility after 8:00pm because it was not safe for them.
-She would not want her family members to be out in the community after 8:00pm, because it was not safe.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 18<br><br>Review of an electronic order from Resident #3's psychiatrist dated 08/23/24 revealed:<br>-The resident needed to be supervised at all times until he could be seen for a follow up appointment for an evaluation.<br>-The resident was a flight risk, and due to his mental health status, it was a safety issue for the resident to be unaccompanied outside of the facility.<br>-The facility needed to provide accommodations for Resident #3 to be escorted by staff to leave the building.<br>-The resident was scheduled for an appointment with his psychiatrist on 08/27/24 at 9:00am.<br><br>Review of the facility sign in/out log revealed:<br>-Resident #3 signed out of the facility on 08/23/24, the resident documented that he left the facility at 1:00pm, and there was no time of return.<br>-Resident #3 signed out of the facility on 08/23/24 a second time, there was no time of when he left and no time of return.<br><br>Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 08/24/24, there was no time of when he left, no time of return, and no staff signature.<br><br>Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 08/25/24, there was no time of when he left and no time of return.<br><br>Review of an Incident Report dated 08/26/24 revealed:<br>-The date of the incident was 08/26/24 at 9:55pm.<br>-Resident #3 walked out of the facility and law enforcement was called to report the resident left | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 19 | C 243 | | |

the facility.
-The resident returned to the facility on 08/26/24 at 10:26pm.
-She did not call local law enforcement since the resident returned by 10:26pm.

Review of a second Incident Report dated 08/26/24 revealed:
-The Administrator documented that local law enforcement were called a few times due to the resident leaving the facility and not returning within 15 to 30 minutes of signing out in the facility sign in/out log.
-The Administrator notified the resident's psychiatrist and his guardian.
-The resident was scheduled for an appointment with his psychiatrist on 08/27/24.

Review of a communications Event Report from local law enforcement dated 08/26/24 revealed:
-The call was received on 08/26/24 at 9:26pm.
-The nature of the event was a "Missing/Found Person."
-The caller reported that Resident #3 was advised by staff to not leave the facility, however the resident walked away from the facility.
-The local law enforcement received a call from staff at 10:28pm that Resident #3 had returned to the facility.

Review of a psychiatrist visit note for Resident #3 dated 08/27/24 revealed:
-The resident was seen for evaluation of medication.
-The Administrator of the facility was present for the appointment.
-Resident #3 stated he could "survive by himself."
-The Administrator reported that the resident's guardian only allowed the resident to visit his family member every 3 months; this put a toll on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 20<br>the resident, he walked out of the facility and law enforcement had to be called.<br>-The resident was a high liability because he would walk out and leave the facility.<br>-The Administrator reported that the resident's guardian with Department of Social Services (DSS) was looking for alternative placement for the resident.<br>-The psychiatrist called the resident's guardian with DSS during the appointment and obtained an update from the guardian.<br>-The Administrator reported that the resident continued to walk away from the facility without supervision and the facility did not have extra staff to supervise the resident.<br>-The Administrator was quoted in the psychiatrist note, "maybe we give him a probation period effective today for 2 hours unsupervised, the other guys are unsupervised, we are a licensed family care home, we have to have orders, we are like their maids."<br>-The resident's mood was alert and angry, his insight was impaired, and his judgement was impaired.<br>-The resident was agitated during the visit.<br>-The resident reported that he felt like he was treated like a child, he wanted to be able to do what the other resident did and be on his own.<br>-The psychiatrist discussed with the Administrator that she recommended she consult with the resident's guardian if she could not meet the resident's needs.<br>-The psychiatrist also recommended the resident be transferred to a higher level of care due to safety and endanger of other issues if needed.<br>-If the Administrator was unable to obtain a higher level of care for Resident #3, the psychiatrist recommended a trial period of 2 hours of unsupervised time per the Administrators request of 2 hours unsupervised time "if safety and injury | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 21 | C 243 | | |

was not a foreseeable problem".

Review of an electronic order from Resident #3's psychiatrist dated 08/27/24 revealed:
-The Administrator needed to consult with the resident's guardian if the Administrator could not meet the resident's needs.
-The psychiatrist also recommended the resident be transferred to a higher level of care due to safety and endangerment due to other issues if needed.
-The psychiatrist documented that the Administrator reported, "they (DSS) only allow him to go see his family member every three months, it is putting a toll on him so he walks out and we have to call the cops, he is a high liability for us because he leaves/walks out, maybe he needs to go to an inpatient psychiatry hospital, he has missed some of his medications, he had a sitter and he walked away from supervision, we don't have extra staff.
-If the Administrator was unable to obtain a higher level of care for Resident #3, the psychiatrist recommended a trial period of 2 hours of unsupervised time per the Administrators request if safety and injury was not a foreseeable problem.
-There was an order for 2 hours unsupervised with check in and check out procedure, per the Administrator's request.

Review of an Incident Report dated 08/27/24 at 8:40pm revealed:
-Resident #3 walked out of the facility, law enforcement was called to report the resident left the facility.
-The Administrator was notified that the resident left the facility.

Review of a progress note completed by the SIC

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 22<br>on 08/27/24 at 8:55pm revealed:<br>-The SIC called law enforcement because Resident #3 left the facility on 08/27/24 at 8:55pm.<br>-The SIC called law enforcement because Resident #3 left the facility on 08/26/24 at 9:55pm.<br>-The SIC called the Administrator on 08/26/24 and 08/27/24 to report Resident #3 had left the facility.<br><br>Review of a communications Event Report from local law enforcement dated 08/27/24 revealed:<br>-The call was received on 08/27/24 at 8:26am.<br>-The nature of the event was a "Missing/Found Person."<br>-The Administrator called to inform local law enforcement that Resident #3 left the facility, she identified the streets that the resident walked toward when he left and reported the resident had mental health issues.<br>-Local law enforcement located Resident #3 at a local convenience store at 8:54pm and was transported back to the facility.<br><br>Review of a second communications Event Report from local law enforcement dated 08/27/24 at 7:19pm revealed:<br>-The call was received on 08/27/24 at 7:19pm.<br>-The nature of the event was a "Missing/Found Person."<br>-A staff person called local law enforcement to report the resident had returned to the facility.<br>-The officer stopped at the facility and spoke with the resident who had walked to the store to purchase cigarettes and a soft drink.<br><br>Review of mapquest.com on 09/06/24 revealed:<br>-The convenience store was located on a five-lane highway. | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 23 | C 243 | | |

-The estimated distance from the facility to the convenience store was observed 09/05/24 at 5:20pm was 0.3 miles.
-The average time of walking distance from the facility to the convenience store was 7 minutes.
-To walk from the facility to the convenience store, Resident #3 would cross 3 residential intersections of two-lane streets
-The major intersection had traffic that traveled two different ways.
-The speed limit on the five lane highways was 35 mph.

Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 08/28/24, the resident documented that he left the facility at 3:45pm, there was no time of return, and no staff signature.

Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 08/29/24, there was no time of when he left, there was documentation the resident returned at 6:30pm, and there was no staff signature.

Review of a progress note completed by the SIC on 08/30/24 at 10:34pm revealed:
-Resident #3 left the facility on 08/30/24 at 6:30pm.
-She called law enforcement at 8:45pm because the resident did not return to the facility after his 2 hours of unsupervised time.
-The SIC called the local DSS and reported the resident to adult protective services.

Review of a communications Event Report from local law enforcement dated 08/30/24 revealed:
-The call was received on 08/30/24 at 8:52pm.
-The nature of the event was a "Missing/Found Person."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 24 | C 243 | | |

-A staff person called local law enforcement to report the resident had been missing from the facility since 6:30pm.
-Law enforcement received a call from the same staff person that Resident #3 returned to the facility at 10:16pm.

Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 08/31/24, there was no time of when he left, no time of return, and no staff signature.

Review of the facility sign in/out log revealed Resident #3 signed out of the facility on 09/01/24, there was no time of when he left, no time of return, and no staff signature.

Observation of the facility on 09/04/24 at 8:10am revealed the Administrator arrived and unlocked the front door to the facility.

Interview with the Administrator on 09/04/24 at 8:15am revealed:
-Resident #3 walked out of the facility earlier this morning because he was "mad."
-The resident reported he was "mad" because another resident took his cigarettes.
-The resident missed the bus that provided transportation to a Psychosocial Rehabilitation Program (PSR) earlier this morning because he left the facility.
-She did not know where Resident #3 was, he usually walked to different businesses in the community.
-She left the facility earlier this morning and locked the facility.

Second interview with the Administrator on 09/04/24 at 9:19am revealed:
-She had to leave the facility to transport a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 25 | C 243 | | |

resident to a medical appointment and locked the facility.
-She was not aware of where Resident #3 was as he had not returned to the facility.
-She had not looked for Resident #3 when she arrived at the facility at 8:10am because she did not have time.
-The SIC who lived across the street had cameras and was responsible for letting Resident #3 back in the facility when he returned.

Observation of the facility on 09/04/24 from 9:26am to 9:37am revealed:
-Resident #3 walked up the street to the driveway of the facility.
-The resident was talking to himself in a loud voice, looking up and down the street, and walked into a neighbor's yard.
-The resident continued to talk to himself loudly while smoking a cigarette.
-The resident paced a few steps up and down the street from the curb of the street to the middle of the street.
-The resident walked onto the sidewalk in front of the facility when two cars drove down the street.
-The resident walked up to the van in the facility driveway and nodded his head several times as he walked around the van back to the street.
-The resident sat on the front steps of the facility and then returned to the street in front of the facility.
-The SIC, who lived across the street, walked to the facility at 9:37am, spoke to Resident #3, unlocked the facility and walked into the facility with Resident #3.

Observation of Resident #3 and the SIC on 09/04/24 at 9:51am revealed the SIC and Resident #3 left the facility in a facility van and the SIC returned to the facility without Resident #3 at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 26<br>10:30am.<br><br>Interview with the SIC on 09/04/24 at 10:30am revealed:<br>-She was not currently on duty, and the Administrator had not given her any instructions regarding what to do when Resident #3 returned to the facility or if he did not return to the facility that morning when he left.<br>-She had cameras at her house and happened to see that Resident #3 had returned to the facility.<br>-The facility was locked when Resident #3 returned to the facility, so she called the Administrator, and she drove Resident #3 to where the Administrator was as the Administrator instructed her to do.<br><br>Review of an Incident Report dated 09/06/24 revealed:<br>-The resident did not return to the facility after his 2 hour unsupervised visit; the resident left at 2:30pm and had not returned by 4:30pm.<br>-The resident's guardian and local Adult Home Specialist were emailed that the resident had not returned by 4:40pm.<br>-The Administrator attempted to contact the resident's psychiatrist, but the provider was not available.<br><br>Review of the facility sign in/out log revealed Resident #3 signed his name on the form on 09/06/24, there was no time of when he left, no time of return, and no staff signature.<br>Observation of the Administrator on 09/06/24 at 4:37pm on a telephone call with local law enforcement revealed:<br>-She called law enforcement to report that Resident #3 had not returned to the facility after his 2 hours of unsupervised time; the resident left the facility at 2:30pm. | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 27<br>-She reported that it was the facility's policy to call law enforcement when the resident did not return after his 2 hours of unsupervised time within 15 to 30 minutes.<br>-She reported the resident as a missing resident.<br>-There were 2 additional staff at the facility; no staff were observed attempting to locate the resident.<br>-The Administrator called Resident #3's legal guardian to report that she called the police because the resident had not returned to the facility.<br>-The legal guardian reminded the Administrator that the resident required 24 hour supervision, and he was not to be left unsupervised at any time due to his recent mental health crisis.<br>-The Administrator explained to the legal guardian that it was her understanding that the resident was allowed to have 2 hours of unsupervised time in the community since his psychiatrist wrote an order for 2 hours of unsupervised time<br>-The legal guardian reminded the Administrator that the facility was responsible for Resident #3 and he required 24 hour supervision to ensure his safety.<br><br>Review of a communications List of Events Log from local law enforcement dated 09/06/24 revealed:<br>-The call was received on 09/06/24 at 4:36pm.<br>-The Administrator called local law enforcement to report Resident #3 had not returned to the facility after his 2 hours of unsupervised time and was wandering.<br>-Local law enforcement located the resident at a local convenience store after speaking with a neighbor near the facility who reported the resident had been helping the homeowner with home repairs.<br>-Local lawenforcement transported the resident | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 28<br>back to the facility.<br>-The resident had walked to the convenience store to purchase snacks and a soft drink.<br><br>Review of mapquest.com on 09/06/24 revealed:<br>-The convenience store was located on a five-lane highway.<br>-The estimated distance from the facility to the convenience store was observed 09/05/24 at 5:20pm was 0.3 miles.<br>-To walk from the facility to the convenience store, Resident #3 would cross 3 residential intersections of two-lane streets<br>-The major intersection had traffic that traveled two different ways.<br>-The speed limit on the five lane highways was 35 mph.<br><br>Review of a communications List of Events Log from local law enforcement dated 09/06/24 revealed:<br>-The call was received on 09/06/24 at 8:20pm.<br>-A staff person called local law enforcement to report Resident #3 left the facility and had not returned.<br>-The staff person informed law enforcement that the resident walked away all the time.<br>-Local law enforcement observed the resident walking on a five lane highway at 8:41pm.<br>-The resident returned to the facility at 9:10pm, and reported to local law enforcement that he left to go get a cigarette and soft drink.<br><br>Observation of the facility on 09/06/24 at 5:28pm revealed:<br>-A police officer entered the home to speak with the Administrator.<br>-The Administrator reported that the resident had not returned from his 2 hours of unsupervised time in the community, and she needed to file a | C 243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 29 | C 243 | | |

missing person report.
-The officer reviewed with the Administrator that the last time she was at the facility on 08/22/24 due to Resident #3 leaving the facility and not returning, that the Administrator informed her that the resident required 24 hour supervision.
-The Administrator explained that she had last informed the police officer that Resident #3 could leave the facility unsupervised as long as he returned to the facility by 8:00pm.
-The police officer went outside to avoid further conflict with the Administrator.

Interview with the police officer on 09/06/24 at 5:35pm revealed:
-She was informed by the Administrator on 08/22/24, the resident was allowed to be unsupervised in the community, but he was required to return to the facility at 8:00pm each evening.
-She was very familiar with Resident #3 because she had been called to the facility numerous times by staff who reported the resident was missing.

Review of a text message from a sergeant with local law enforcement dated 09/06/24 at 8:43pm revealed the sergeant texted the state surveyor to report they received a telephone call from the facility that Resident #3 left the facility and was missing.

Interview with the Administrator on 09/06/24 at 9:40am revealed:
-She attended Resident #3's psychiatrist evaluation on 08/27/24.
-She informed the psychiatrist that the resident was not a danger to himself or others, and she was not concerned that the resident would attempt to leave the facility.

C 243 | C 243

Continued From page 30

-Resident #3's legal guardian expected the resident to be supervised at all times until his appointment with his psychiatrist on 08/27/24.
-Resident #3's legal guardian was fine with the resident not being supervised at all times after his psychiatrist evaluation on 08/27/24 because their goal was for Resident #3 to live on his own eventually.
-The psychiatrist provided an order on 08/27/24 that the resident could have 2 hours of unsupervised time away from the facility.
-She did not remember the resident's legal guardian ever telling her that the resident had to be supervised at all times even after the resident was evaluated by his psychiatrist.
-Resident #3 should not be out of the facility unsupervised after 8:00pm because it was a safety issue for the resident; he could get hit by a car, harmed by someone, or picked up for human trafficking.
-She did not agree with the resident's legal guardian's recommendation that the resident be supervised at all times; she allowed the resident 2 hours of unsupervised visits a day as the psychiatrist ordered.
-She directed the facility staff to call law enforcement if the resident had not returned from his 2 hours of unsupervised time within 15 to 30 minutes and to report the resident as a missing person.

Interview with Resident #3's legal guardian with a Department of Social Services (DSS) on 09/04/24 at 9:45am revealed:
-She spoke with the Administrator of the facility on 08/22/24 and 08/23/24 to inform her that Resident #3 required constant supervision due to his mental health crisis.
-She explained to the Administrator several times that under no circumstances should the resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 243 | Continued From page 31 be without supervision.<br><br>Attempted telephone calls to Resident #3's psychiatrist on 09/05/24 at 1:20pm, 09/06/24 at 9:10am, and 09/06/24 at 1:46pm were unsuccessful.<br>______________________<br>The facility failed to provide supervision to Resident #3 who was constantly disoriented, wandered, had a diagnoses of intellectual disability and schizophrenia who repeatedly left the facility without supervision; one of which he eloped from the facility and obtained transportation from a local business owner to visit his family over an hour away. The facility staff did not actively search for the resident over 13 hours or file a report to local law enforcement that the resident was missing. This failure of the facility resulted in serious neglect and constitutes a Type A1 Violation.<br>______________________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on September 6, 2024, for this violation. | C 243 | | |
| C 301 | 10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services<br><br>10A NCAC 13G .0906 Other Resident Services<br><br>(f) Visiting.<br>(1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator;<br>(2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information | C 301 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | Continued From page 32<br>about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home;<br>(3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party;<br>(4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, interviews, and record reviews the facility failed to immediately notify local law enforcement, the County Department of Social Services and the guardian for 1 of 1 resident (#3) who was constantly disoriented and the whereabouts of the resident were unknown.<br><br>The findings are:<br><br>Review of the facility's undated Identification and Supervision of Wandering Residents policy revealed:<br>-The facility would identify residents who developed disorientation and wandering behaviors and keep them safe until a secured environment could be obtained for the resident. | C 301 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **FCL033016** | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | Continued From page 33 | C 301 | | |

-When a cognitively impaired resident began to wander, staff should provide a secure boundary or perimeter to safely accommodate the resident.
-Staff would be trained on the importance of preventing unsafe wandering and supervision would be provided to meet the identified needs of the resident.
-The Administrator, Supervisor- In- Charge (SIC), and staff should observe the location of each resident at risk for elopement with ongoing communication between staff if necessary to transfer information related to the presence of behaviors that indicate elopement is likely.

Review of Services Offered in an undated facility handbook revealed:
-The facility would provide residents with twenty-four hour supervision by compassionate and trained staff.
-The facility would provide immediate response in case of an emergency, accident, or incident involving a resident.

Review of Resident #3's current FL-2 dated 09/21/23 revealed:
-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning.
-The resident was ambulatory and constantly disoriented.
-The resident wandered and was verbally abusive.
-The resident's recommended level of care was family care home.

Review of Resident #3's current care plan dated 10/03/23 revealed:
-The resident wandered and was verbally abusive.
-The resident was sometimes disoriented,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | Continued From page 34 | C 301 | | |

forgetful and needed reminders.
-The resident required limited assistance with eating, toileting, bathing, dressing, and grooming.

Review of a progress note completed by the Administrator dated 08/21/24 at 8:30pm revealed:
-She told Resident #3 at 8:30pm that he needed to return the facility in 15 to 30 minutes or else staff would call law enforcement.
-She documented the resident responded "okay."
-She spoke with the SIC at 9:15pm and the SIC reported the resident had been walking in and out of the facility.
-She instructed the SIC to contact law enforcement if the resident had not returned in 15 to 30 minutes.

Review of a communications Event Report from the local law enforcement office dated 08/22/24 revealed:
-The call was received on 08/22/24 at 6:41am.
-The nature of the event was a "Missing/Found Person".
-Resident #3 was last seen by the Administrator at approximately 8:00pm the previous evening.
-Resident #3 was walking in an area approximately 2 blocks from the facility when she stopped to instruct him to go back to the facility to take his medications.
-It was reported by staff that Resident #3 did not return to the facility throughout the night on 08/21/24.

Review of a progress note completed by the Administrator dated 08/22/24 at 7:30am revealed:
-Law enforcement was present when she arrived at the facility at 7:30am.
-She was not aware that Resident #3 had not returned to the facility in the evening of 08/21/24.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | Continued From page 35 | C 301 | | |

Review of an electronic chart note from Resident #3's psychiatrist dated 08/22/24 revealed:
-The Administrator of the facility called and informed staff that Resident #3 had eloped on 08/22/24.
-The Administrator reported that she called law enforcement and filed a missing person report.
-The Administrator reported that she called the resident's guardian to report the resident eloped.

Review of a facility Incident Report dated 08/23/24 revealed:
-The date of the incident was 08/22/24 at 6:15am.
-The incident type was a missing person.
-The missing person was identified as Resident #3.
-Local law enforcement was called due to Resident #3 not returning to the facility in a timely manner; there was no date or time documented.
-Staff made a missing person's report; there was no date or time documented.
-The Administrator notified Resident #3's guardian and psychiatrist.
-Resident #3 was found; there was no date or time documented.
-Follow-up actions included extra precautions to protect the resident's safety, an appointment was made with the resident's psychiatrist and an order was obtained from Resident #3's psychiatrist was obtained for his safety.

Review of an electronic order from Resident #3's psychiatrist dated 08/23/24 revealed:
-The resident needed to be supervised at all times until he could be seen for a follow up appointment for an evaluation.
-The resident was a flight risk, and due to his mental health status, it was a safety issue for the resident to be unaccompanied outside of the facility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______<br>B. WING ______ | R-C<br>**09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE**<br>**ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | Continued From page 36<br>-The facility needed to provide accommodations for Resident #3 to be escorted by staff to leave the building.<br>-The resident was scheduled for an appointment with his psychiatrist on 08/27/24 at 9:00am.<br><br>Interview with Resident #3's legal guardian with a Department of Social Services (DSS) on 09/04/24 at 9:45am revealed:<br>-Resident #3 called her from a local business on 08/21/24 and left her a voicemail that he had been kicked out of the facility because he did not go to his psychosocial rehabilitation program (PSR).<br>-She was informed by the Administrator of the facility on 08/22/24 that the resident was missing and left the facility on the evening of 08/21/24.<br>-She contacted local law enforcement where the facility was located to report the resident as a missing person on 08/22/24.<br>-She also contacted local law enforcement where his family member lived to file a missing person report.<br>-She called the local business owner near the facility because the resident called her often from that location.<br>-The local business owner reported that Resident #3 came to his business on 08/21/24 upset that he had been kicked out of the facility.<br>-The resident wanted a ride to a family member who was located 66.8 miles away from the facility; one hour and six minutes.<br>-The local business owner provided a ride to Resident #3 to his family members location and left the resident with his family member.<br>-Her agency received a telephone call from local law enforcement at 10:00pm on 08/22/24 that the resident had been located with his family member 66.8 miles away from the facility.<br>-She notified the Administrator that Resident #3 | C 301 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | | C 301 | | |

Continued From page 37

had been located and staff with DSS would be driving him back to the facility on 08/22/24 so the Administrator could notify the local law enforcement near the facility that the resident had been found at 10:00pm.
-Staff with DSS provided the resident transportation back to the facility on 08/22/24 and he arrived back at the facility at approximately 12:00am on 08/23/24.

Interview with the Adult Home Specialist for the local Department of Social Services on 08/30/24 at 11:19am revealed she received an incident report from the facility on 08/23/24 reporting the elopement of Resident #3 that occurred on 08/21/24.

Interview with a Supervisor-In-Charge (SIC) on 09/06/24 at 4:16pm revealed:
-She did not know what time Resident #3 left the facility on 08/21/24 because he had already left the facility when she arrived to work at 7:00pm and she did not see him the rest of the night.
-She sent a text to the Administrator at approximately 11:00pm when he had not returned, and the Administrator instructed her to call local law enforcement if he did not return in an hour.
-It was not unusual for Resident #3 to go in and out of the facility and would sometimes sit on the porch until approximately 4:00am.
-She checked the porch through the night but Resident #3 did not return to the facility.
-She did not call the local law enforcement until the next morning because they got mad due to the facility calling them often regarding Resident #3 walking out.
-She thought Resident #3 would return to the facility.
-She did not call or text the Administrator after

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | Continued From page 38<br>11:00pm on 08/21/24 and the Administrator did not call or text to see if Resident #3 had returned during the night.<br><br>Interview with the Administrator on 09/04/24 at 2:45pm revealed:<br>-She left the facility at approximately 8:30pm on 08/21/24.<br>-She was in her car in the driveway of the facility when she told Resident #3 to go into the facility within 15-30 minutes or local law enforcement would be called; Resident #3 was outside the facility at the curb smoking a cigarette at that time.<br>-She spoke with the SIC on duty via phone at 9:15pm and told her to call local law enforcement if he did not return within the hour.<br>-When she arrived to work just after 7:00am on 08/22/24, local law enforcement was at the facility.<br>- She was not notified prior to her arrival that Resident #3 did not return to the facility all night and that staff had not called local law enforcement until the morning of 08/22/24.<br>-Resident #3's legal guardian was notified on 08/22/24 of the elopement, Resident #3 was found in another town with a family member around 10:00pm and he was returned to the facility after midnight on 08/23/24; she thought he may have hitchhiked.<br>______________________________<br>The facility failed to immediately notify local law enforcement, the County Department of Social Services and the resident's guardian that Resident #3 was missing from the facility and his whereabouts were unknown. Resident #3 had diagnoses which included intellectual disability, impulse control disorder and schizoaffective disorder, bipolar type and was constantly disoriented. He left the facility on the evening of | C 301 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 301 | Continued From page 39<br><br>8/21/24 and local law enforcement, his guardian and the County Department of Social Services were not notified until 8/22/24. Resident #3 was found in a town over an hour's drive from the facility with family members. This failure resulted in substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation.<br>________________________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/28/24 with amendment on 09/06/24 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 6, 2024. | C 301 | | |
| C 311 | 10A NCAC 13G .0909 Residents' Rights<br><br>10A NCAC 13G .0909 Resident Rights<br>A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A1 VIOLATION<br><br>The Type A1 Violation is abated. Non-compliance continues.<br><br>THIS IS A TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to ensure 4 of 4 residents were treated with respect and dignity related to the Administrator not providing access to the facility and speaking to residents in a manner that made them feel uncomfortable (#1, #2, #3, and #4). | C 311 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 40 | C 311 | | |

The findings are:

Review of Declaration of Resident Rights in an undated facility handbook revealed:
-Every resident had the right to be treated with respect, consideration, dignity, and full recognition of their individuality and their right to privacy.
-Every resident should receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

a. Review of Resident #1's current FL-2 dated 08/13/24 revealed:
-Diagnoses included schizoaffective disorder bipolar type, delusional disorder, hyperthyroidism and asthma.
-He was constantly disoriented.
-There was an order for 3 hours of unsupervised time daily with check in and out of facility.

Review of Resident #1's current care plan dated 08/13/24 revealed:
-He was verbally abusive and injurious to property.
-He had a history of developmental disabilities.
-He required limited assistance from staff for eating, toileting, bathing, dressing and personal hygiene.
-He was totally dependent of staff for medication administration.

Interview with Resident #1 on 09/04/24 at 11:45am revealed:
-The Administrator said she gave residents the "privilege of leave" for 3 hours out of the facility each day.
-The Administrator made him take 3 hours of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ___ B. WING ___ | R-C **09/06/2024** |

NAME OF PROVIDER OR SUPPLIER: **A CHILD'S HOPE FAMILY CARE HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE: **329 PARK AVENUE ROCKY MT, NC 27801**

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 41 | C 311 | | |

unsupervised leave outside of the facility whether he wanted to or not.
-The Administrator did not want to hire staff to be at the facility during the day and if the Administrator wanted to leave the facility, then she made them go outside.
-Sometimes it was too hot, or he did not have money so he did not want to go out of the facility on his own and she would make him go with her to another business that she operated where he sat outside under a canopy at a table.
-He once told the Administrator that it looked like it was going to rain but she told him it was time to sign out of the facility.
-He had not talked with the Administrator about how he felt about being forced to leave each day because he did not feel like she would listen.

Interview with the Administrator on 09/04/24 at 2:45pm revealed:
-Resident #1 sometimes did not want to go outside for unsupervised leave each day.
-Sometimes Resident #1 and the other residents would go with her to another shop that she owns during their leave time if they chose not to go out.

Refer to interview with the Supervisor in Charge (SIC) on 09/04/24 at 10:30am.

Refer to interview with the Administrator on 09/04/24 at 2:45pm.

b. Review of Resident #2's current FL-2 dated 08/14/24 revealed:
-Diagnoses included neurocognitive disorder. traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH). (SIADH is a metabolic disorder that cause the body to produce too much urine and results in low blood pressure and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 42<br>dehydration.)<br>-He was ambulatory and constantly disoriented.<br>-There was an order for 3 hours of unsupervised daily with check in and out of facility.<br><br>Review of Resident #2's current care plan dated 07/25/24 revealed:<br>-The resident was verbally abusive and injurious to property.<br>-The resident had a history of developmental disabilities and mental health diagnosis.<br>-The resident required limited assistance with eating, toileting, bathing, dressing, and grooming.<br><br>Interview with Resident #2 on 09/04/24 at 12:35pm revealed:<br>-He was recently approved by his psychiatrist for 3 hours of unsupervised time daily away from the facility.<br>-The Administrator would tell him when his 3 hours of unsupervised time began; it was not his choice.<br>-The Administrator would direct the residents to sign out on the sign in/sign out log and they had to leave the facility when she said it's time to go.<br>-The resident had to leave the facility for their unsupervised time when the Administrator told them it was time to go.<br>-Resident #2 would walk to the community center and local stores.<br>-The Administrator locked the facility so if he got too hot and wanted to go back to the facility he could not get in the facility because the Administrator had left and locked the facility.<br>-The Administrator usually had them sign out from 3:00pm to 6:00pm for their unsupervised time.<br>-Sometimes if he did not feel well, he would go with the Administrator to her shop and sit under a canopy on a bench and wait until they could | C 311 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 43<br>return to the facility.<br><br>Refer to interview with the SIC on 09/04/24 at 10:30am.<br><br>Refer to interview with the Administrator on 09/04/24 at 2:45pm.<br><br>c. Review of Resident #3's current FL-2 dated 09/21/23 revealed:<br>-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, borderline intellectual functioning, and hearing loss.<br>-The resident was ambulatory and constantly disoriented.<br>-The resident wandered and was verbally abusive.<br>-The resident's recommended level of care was family care home.<br><br>Review of Resident #3's current care plan dated 10/03/23 revealed:<br>-The resident wandered and was verbally abusive.<br>-The resident was sometimes disoriented, forgetful and needed reminders.<br>-The resident required limited assistance with eating, toileting, bathing, dressing, and grooming.<br><br>Review of an electronic order from Resident #3's psychiatrist dated 08/27/24 revealed:<br>-The Administrator needed to consult with the resident's guardian if the Administrator can not meet the resident's needs.<br>-The psychiatrist also recommended the resident be transferred to a higher level of care due to safety and endanger of other issues if needed.<br>-If the Administrator was unable to obtain a higher level of care for Resident #3, the psychiatrist | C 311 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 44 | C 311 | | |

recommended a trial period of 2 hours of unsupervised time per the Administrators request if safety and injury was not a foreseeable problem.
-There was an order for 2 hours unsupervised with check in and check out procedure.

Interview with Resident #3 on 09/06/24 at 8:00am revealed:
-His psychiatrist approved for him to have 2 hours of unsupervised time in the community.
-Sometimes when he was at the facility with the other residents after their PSR program, the Administrator made them sign out, leave the facility and the Administrator locked the facility.
-He enjoyed walking to visit friends at local stores in the community, he helped some shops with taking the trash out and was given a little bit of money.
-There were a few times he walked back to the facility and the door was locked; so, he waited on the front porch steps for someone to come let him in the facility.

Refer to interview with the SIC on 09/04/24 at 10:30am.

Refer to interview with the Administrator on 09/04/24 at 2:45pm.

d. Review of Resident #4's current FL-2 dated 01/29/24 revealed:
-Diagnoses included intellectual disabilities, schizoaffective disorder bipolar type, and hyperlipidemia.
-The resident was ambulatory and constantly disoriented.
-The resident wandered and was verbally abusive.
-The resident's recommended level of care was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 45 | C 311 | | |

family care home.

Review of a psychiatrist order for Resident #4 dated 08/27/24 revealed the resident could have 3 hours unsupervised time with check in and check out of facility.

Interview with Resident #4 on 09/04/24 at 12:40pm revealed:
-His psychiatrist approved him to have 3 hours of unsupervised time daily.
-The residents were not always allowed to choose the 3 hours they wanted to be unsupervised; the Administrator would tell them when to sign out as a group.
-The Administrator would lock the facility and come back to the facility within 3 hours.
-There were times that he told the Administrator that it looked like it was going to rain when they were required to sign out.
-The Administrator usually left a facility van at the facility so residents could get in the van if it rained, or they became tired.
-He had gotten in the van a few times because he was tired of walking in the community.

Refer to interview with the SIC on 09/04/24 at 10:30am.

Refer to interview with the Administrator on 09/04/24 at 2:45pm.

______________________

Interview with the SIC on 09/04/24 at 10:30am revealed:
-She lived across the street from the facility.
-She had cameras at her house and could see when a resident returned from their unsupervised time.
-If she was at home and saw a resident return to the facility before the Administrator returned, she

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 46 | C 311 | | |

would unlock the facility and sit with the resident until the Administrator returned to the facility.

Interview with the Administrator on 09/04/24 at 2:45pm revealed:
-She encouraged the residents to sign out after they returned from their Psychosocial Rehabilitation Program (PSR).
-Residents usually signed out of the facility from 3:00pm to 6:00pm.
-The residents usually took their unsupervised leave at the same time and the facility was locked during that time.
-The residents could get in the facility van if it started to rain and she had not returned to the facility from the shop.
-Sometimes the residents chose to ride with her to her local shop and they would hang out at her shop.
-If a resident returned to the facility earlier than 6:00pm, the Supervisor in Charge (SIC) lived across the street, had cameras that faced the facility and the SIC would open the facility for the resident.
-Once a resident returned to the facility and the SIC opened the facility; the SIC would stay with that resident until other staff returned to the home to relieve her.

2. Interview with Resident #1 on 09/04/24 at 11:45am revealed:
-The Administrator was not always truthful, so he tried to stay quiet because when he brought up concerns to the Administrator, she threatened to send him to back to the hospital and this made him feel angry.
-He felt like the Administrator did not care about his wishes.
-The Administrator created tension in the facility by her tone of voice and how she spoke with

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 47 | C 311 | | |

residents.
-The Administrator was argumentative and controlling; the tension she created impeded communication.
-He felt she talked down to him and was disrespectful.
-He was bitter about the situation and said, "we are her prey. P-R-E-Y."

Interview with Resident #2 on 09/04/24 at 12:35pm revealed:
-The Administrator talked down to the residents and could be harsh at time when she spoke with them.
-He figured it was just her way of communicating; but he tried not to ask the Administrator any questions.

Interview with Resident #3 on 09/06/24 at 8:00am revealed:
-The Administrator talked down to him and was rude.
-He got frustrated frequently when the Administrator talked to him, he felt she talked down to him and did not treat him with respect.
-She often threatened to send him to a home if he did not listen to her and that scared him because he did not want to go to a home.

Interview with Resident #4 on 09/04/24 at 12:40pm revealed:
-He was used to the Administrator talking down to the residents.
-The Administrator was demanding and loud when she talked to the residents.
-He tried to keep quiet to keep the Administrator from fussing at him.

Observation of the Administrator with staff and Resident's #1, #2, and #4 on 09/06/24 at 3:10pm

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 48<br>revealed:<br>-The Administrator held a meeting with staff and residents in the family room to review resident rights and resident's unsupervised time at the facility.<br>-She informed the residents that she was requesting as of today (09/06/24) that they not call her at night with questions or concerns but to report any questions or concerns to the staff on duty.<br>-The Administrator informed residents that she would not be working any shifts after today; if residents had any questions or concerns, they needed to contact the staff on duty and they would inform her of any concerns residents had.<br>-She explained to staff with resident's present that the new change in procedure was to prevent resident's from feeling that she spoke with them disrespectfully.<br>-She explained to residents that she wanted to ensure that "y'all don't' think I'm talking to you aggressively."<br>-A personal care aide (PCA) in the meeting told to the Administrator, "The issue is not how we feel, but how the resident's feel when we speak with them."<br>-Resident #2 told the Administrator, "The way you speak now, I get over it."<br>-A PCA responded to Resident #2, "I don't' want to hear it."<br>-The PCA stated to the group, "the only one that tried to talk back at me was Resident #3 and I told him to get out."<br><br>Interview with the PCA on 09/06/24 at 3:36pm revealed:<br>-It was the resident's right to have unsupervised time and leave the facility unsupervised when they wanted a break.<br>-When a resident left the facility, she was not | C 311 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 49 | C 311 | | |

going to chase them, tackle them, or put her hands on them in any way.
-She was not able to force residents to stay at the facility.
-There were times when she had to speak directly and firmly with the residents to ensure they understood the rules.

Interview with the Administrator on 09/04/24 at 3:30pm revealed:
-She encouraged the residents to sign out after they returned from their Psychosocial Rehabilitation Program (PSR).
-Residents usually signed out of the facility from 3:00pm to 6:00pm.
-Sometimes the residents chose to ride with her to her local shop and they would hang out at her shop.
-When she left and the residents had left for their unsupervised time, she locked the facility.
-If a resident returned to the facility earlier than 6:00pm, the Supervisor in Charge (SIC) lived across the street, had cameras that faced the facility and the SIC would open the facility for the resident.
-Once a resident returned to the facility and the SIC opened the facility; the SIC would stay with that resident until other staff returned to the home to relieve her.

___________________________________

The facility failed to ensure residents were treated with dignity and respect related to residents that were constantly disoriented being forced to sign out and use allotted unsupervised leave for up to three hours without access to enter the facility because it was locked, no staff were present in the home, and they were unable to gain access back into the facility until someone came to unlock the door which resulted in residents sitting in a van at the facility if it began to rain and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 311 | Continued From page 50<br>complaints of not having money to purchase food or drinks during hot weather, and resident's being spoken to by the Administrator in a demeaning tone that created tension in the home and caused residents to fear bringing up any concerns to the Administrator because they were afraid of upsetting the Administrator. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation.<br>______________________________<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on September 4, 2024, for this violation.<br><br>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 21, 2024 | C 311 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#4) for a medication prescribed to treat a rash. | C 330 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 330 | Continued From page 51 | C 330 | | |

The findings are:

Review of Resident #4's current FL-2 dated 01/29/24 revealed diagnoses included intellectual disabilities, schizoaffective disorder bipolar type, and hyperlipidemia.

Review of Resident #4's dermatologist visit note dated 08/20/24 revealed:
-Resident #4 was seen for a rash on his face.
-The resident complained of scaly and flaky skin on his face after he shaved.
-The resident denied itching or irritated skin on his face.

Review of a physician's order dated 08/20/24 revealed:
-There was an order for Hydrocortisone 2.5% ointment; apply topically on face daily for rash or skin irritation at 8:00am; 2 days on and 2 days off; do not apply on the same days that Nystatin is applied (Hydrocortisone is used to treat skin conditions that cause swelling, redness, itching, and rashes).
-There was an order for Nystatin 100,000 unit/gram, apply topically to face daily for rash at 8:00am, 2 days on, then 2 days off, alternating with the Hydrocortisone (Nystatin is used to treat fungal or yeast infections in the skin).

Review of Resident #4's August 2024 medication administration record (MAR) revealed:
-There was a handwritten entry for Hydrocortisone 2.5% ointment; apply topically on face daily for rash or skin irritation at 8:00am; 2 days on and 2 days off; do not apply on the same days that Nystatin is applied.
-There was documentation that Hydrocortisone 2.5% ointment was administered at 8:00am on 08/21/24, 08/24/24, 08/27/24, and 08/30/24.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 330 | Continued From page 52 | C 330 | | |

-There was a handwritten order for Nystatin 100,000 unit/gram, apply topically to face daily for rash at 8:00am, 2 days on, then 2 days off, alternating with the Hydrocortisone.
-There was documentation that Nystatin 100,000 unit/gram was administered at 8:00am on 08/21/24, 08/24/24, 08/27/24, and 08/30/24.

Review of Resident #4's September 2024 MAR revealed:
-There was a handwritten entry for Hydrocortisone 2.5% ointment, apply topically on face daily for rash or skin irritation, 2 days on and 2 days off, do not apply on days when using Nystatin.
-There was documentation that Hydrocortisone 2.5% ointment was administered on 09/01/24 and 09/04/24.
-There was a handwritten entry for Nystatin 100,000 unit/gram, apply topically to face daily for rash, 2 days on, then 2 days off, alternating with Hydrocortisone 2.5% ointment.
-There was documentation that Nystatin 100,000 unit/gram was administered on 09/01/24 and 09/04/24.

Interview with Resident #4 on 09/05/24 at 9:15am revealed he felt that his face was doing better; there was not as much flaking of his skin on his face.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/06/24 at 1:20pm revealed:
-The facility should alternate the application of Hydrocortisone and Nystatin for Resident #4.
-The instructions were to apply Hydrocortisone 2.5% ointment to the resident's face for 2 days; and then apply Nystatin 100,000 unit/gram to the resident's face for 2 days.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 330 | Continued From page 53<br><br>Interview with the Administrator on 09/06/24 at 1:30pm revealed:<br>-She had transcribed the order onto the August 2024 MAR for Resident #4 after he received the order from his dermatologist.<br>-She evidently became confused and did not follow the medication instructions as prescribed.<br>-She should not have applied Hydrocortisone and Nystatin to the resident's face at the same time.<br>-She received the printed MAR for September 2024 with instructions for the Hydrocortisone and Nystatin for Resident #4's rash.<br>-She realized today that she made the same mistake in September 2024 by applying the Hydrocortisone and Nystatin to the resident's face daily.<br>-She should have read the prescribing instructions more clearly to avoid making the mistake of applying both medications to Resident #4's face daily.<br><br>Attempted interview with the medication aide (MA) on 09/05/24 at 1:55pm was unsuccessful.<br><br>Attempted telephone interview with Resident #4's dermatologist on 09/06/24 at 11:21am was unsuccessful. | C 330 | | |
| C 341 | 10A NCAC 13G .1004 (i) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br><br>(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 54 | C 341 | | |

resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure the recording of the administration of medication on the medication administration record immediately following administration of the medication to the resident for 4 of 4 residents (#1, #2, #3, #4).

The findings are:

Review of a binder on the top of the medication cart on 09/04/24 revealed:
-The binder contained the electronic medication administration records (eMAR) for each resident of the facility.
-There was a handwritten note that read, "I will fill in my days that I worked in the morning. I did not have my list of days with me." (The note was not dated.)

1. Review of Resident #1's current FL-2 dated 08/13/24 revealed:
-Diagnoses included schizoaffective disorder bipolar type, delusional disorder, hyperthyroidism and asthma.
-He was constantly disoriented.
-There was an order for Olanzapine 20mg to be administered daily after dinner. (Olanzapine is a medication used to treat psychosis.)
-There was an order for Lithium Carbonate 300mg to be administered every morning. (Lithium Carbonate is a medication used to stabilize mood.)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 55 | C 341 | | |

-There was an order for Levothyroxine 25mcg to be administered every day before breakfast. (Levothyroxine is a medication used to treat thyroid disorders.)
-There was an order for Pantoprazole Sodium delayed release 40mg to be administered every morning. (Pantoprazole is a medication used to treat gastroesophageal reflux disease.)
-There was an order for Fluticasone 0.05%, 1 spray to be administered into each nostril every morning. (Fluticasone is a medication used to treat seasonal allergies.)
-There was an order for a nutritional supplement, 1 can to be administered every day. (Nutritional supplements are used for nutritional support.)
-There was an order for Lorazepam 0.5mg to be administered every night at bedtime. (Lorazepam is a medication used to treat anxiety.)
-There was an order for Lithium Carbonate 300mg, 2 tablets to be administered daily after supper.
-There was an order for Metformin HCL extended release 500mg to be administered each day after dinner. (Metformin is a medication used to stabilize blood sugar levels.)
-There was an order for Fenofibrate 54 mg to be administered each night after dinner. (Fenofibrate is a medication used to treat high cholesterol.)
-There was an order for Montelukast Sodium 10mg to be administered each night at bedtime. (Montelukast is a medication used to treat seasonal allergies.)

Review of Resident #1's medication administration record (MAR) for September 2024 on 09/04/24 revealed:
-There was a computerized entry for Olanzapine 20mg to be administered daily after dinner.
-There was no documentation Olanzapine 20mg was administered each evening at 5:00pm on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 56<br>09/01/24 through 09/03/24.<br>-There was a computerized entry for Lithium Carbonate 300mg to be administered every morning.<br>-There was no documentation Lithium Carbonate 300mg was administered each morning at 8:00am on 09/01/24 through 09/04/24.<br>-There was a computerized entry for Levothyroxine 25mcg to be administered every day before breakfast.<br>-There was no documentation Levothyroxine 25mcg was administered each morning at 6:00am on 09/01/24 through 09/04/24.<br>-There was a computerized entry for pantoprazole sodium delayed release 40mg to be administered every morning.<br>-There was no documentation Pantoprazole Sodium delayed release 40mg was administered each morning at 8:00am on 09/01/24 through 09/04/24.<br>-There was a computerized entry for Fluticasone 0.05%, 1 spray to be administered into each nostril every morning.<br>-There was no documentation Fluticasone 0.05%, 1 spray into each nostril was administered each morning at 8:00am on 09/01/24 through 09/04/24.<br>-There was a computerized entry for a nutritional supplement with instructions to drink one can every day for supplement.<br>-There was no documentation the nutritional supplement, 1 can, was administered each morning at 8:00am on 09/01/24 through 09/04/24.<br>-There was a computerized entry for Lorazepam 0.5mg to be administered every night at bedtime.<br>-There was no documentation Lorazepam 0.5mg was administered each evening at 8:00pm on 09/01/24 through 09/03/24.<br>-There was a computerized entry for Lithium Carbonate 300mg, 2 tablets to be administered daily after supper. | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 57<br>-There was no documentation Lithium Carbonate 300mg, 2 tablets was administered each evening at 6:00pm on 09/01/24 through 09/03/24.<br>-There was a computerized entry for Metformin HCL extended release 500mg to be administered each day after dinner.<br>-There was no documentation Metformin HCL extended release 500mg was administered each evening at 6:00pm on 09/01/ 24 through 09/03/24.<br>-There was a computerized entry for Fenofibrate 54 mg to be administered each night after dinner.<br>-There was no documentation Fenofibrate 54 mg was administered each evening at 6:00pm on 09/01/24 through 09/03/24.<br>-There was a computerized entry for Montelukast Sodium 10mg to be administered each night at bedtime.<br>-There was no documentation Montelukast Sodium 10mg was administered each evening at 8:00pm on 09/01/24 through 09/04/24.<br><br>Second review of Resident #1's MAR for September 2024 on 09/05/24 revealed:<br>-There was documentation Olanzapine 20mg was administered each evening at 5:00pm on 09/01/24 through 09/04/24.<br>-There was documentation Lithium Carbonate 300mg was administered each morning at 8:00am on 09/01/24 through 09/05/24.<br>-There was documentation Levothyroxine 25mcg was administered each morning at 6:00am on 09/01/24 through 09/05/24.<br>-There was documentation Pantoprazole Sodium delayed release 40mg was administered each morning at 8:00am on 09/01/24 through 09/05/24.<br>-There was documentation Fluticasone 0.05%, 1 spray into each nostril was administered each morning at 8:00am on 09/01/24 through 09/05/24.<br>-There was documentation the nutritional | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 58 | C 341 | | |

supplement, 1 can, was administered each morning at 8:00am on 09/01/24 through 09/05/24.
-There was documentation Lorazepam 0.5mg was administered each evening at 8:00pm on 09/01/24 through 09/04/24.
-There was documentation Lithium Carbonate 300mg, 2 tablets were administered each evening at 6:00pm on 09/01/24 through 09/04/24.
-There was documentation Metformin HCL extended release 500mg was administered each evening at 6:00pm on 09/01/24 through 09/04/24.
-There was documentation Fenofibrate 54 mg was administered each evening at 6:00pm on 09/01/24 through 09/04/24.
-There was documentation Montelukast Sodium 10mg was administered each evening at 8:00pm on 09/01/24 through 09/04/24.

Attempted interview with the medication aide (MA) on 09/05/24 at 1:55pm was unsuccessful.

Refer to interview with the pharmacist for the facility's contracted pharmacy on 09/04/24 at 2:09pm.

Refer to interview with the Administrator on 09/04/24 at 8:50am.

Refer to second interview with the Administrator on 09/05/24 at 10:44am.

2. Review of Resident #2's current FL-2 dated 08/14/24 revealed:
-Diagnoses included schizophrenia, neurocognitive disorder and history of a traumatic brain injury.
-He was constantly disoriented.
-There was an order for Haldol 10mg to be administered each day. (Haldol is an antipsychotic medication used to treat

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 59 | C 341 | | |

schizophrenia.)
-There was an order for Linzess 290 mcg to be administered each morning with a full glass of water. (Linzess is used to treat irritable bowel syndrome.)
-There was an order for Multivitamin with minerals to be administered each morning. (Multivitamin with minerals is used for nutritional support.)
-There was an order for Benztropine 1mg to be administered twice daily. (Benztropine is used to prevent side effects that can be caused my antipsychotic medications.)
-There was an order for Lithium Carbonate 300mg to be administered twice daily with food. (Lithium carbonate is a medication used to stabilize mood.)
-There was an order for Clonazepam 0.5mg to be administered twice daily. (Clonazepam is used to treat anxiety.)
-There was an order for Sodium Chloride 1gm, 3 tablets to be administered twice daily. (Sodium Chloride is used to support sodium levels in the blood.)
-There was an order for Ketotifen 0.025%, 1 drop to each eyes each morning and at bedtime. (Ketotifen are used to treat eye discomfort.)
-There was an order for Trazodone 100mg, 2 tablets to be administered each night at bedtime. (Trazodone is used to treat insomnia.)
-There was an order for Haldol 10mg, 2 tablets to be administered each night at bedtime.
-There was an order for Ciclopirox 8% to be applied to the right great toe each morning. (Ciclopirox is used to treat fungal infections.)

Review of Resident #2's medication administration record (MAR) for September 2024 on 09/04/24 revealed:
-There was a computerized entry for Haldol 10mg

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 60<br>to be administered each day and scheduled for 8:00am.<br>-There was no documentation Haldol 10mg was administered on 09/01/24 through 09/04/24.<br>-There was a computerized entry for Linzess 290 mcg to be administered each day and scheduled for 8:00am.<br>-There was no documentation Linzess 290 mcg was administered on 09/01/24 through 09/04/24.<br>-There was a computerized entry for Multivitamin with minerals to be administered each day and scheduled for 8:00am.<br>-There was no documentation Multivitamin with minerals was administered on 09/01/24 through 09/04/24.<br>-There was a computerized entry for Benztropine 1mg to be administered twice daily and scheduled for 8:00am and 8:00pm.<br>-There was no documentation Benztropine 1mg was administered on 09/01/24 through 09/04/24.<br>-There was a computerized entry for Lithium Carbonate 300mg to be administered twice daily with food and scheduled for 8:00am and 8:00pm.<br>-There was no documentation Lithium Carbonate 300mg was administered on 09/01/24 through 09/03/24.<br>-There was a computerized entry for Clonazepam 0.5mg to be administered twice daily and scheduled for 8:00am and 8:00pm.<br>-There was no documentation Lithium Carbonate 300mg was administered on 09/01/24 through 09/03/24.<br>-There was a computerized entry for Sodium Chloride 1GM, 3 tablets to be administered in the morning and after dinner and scheduled for 8:00am and 5:00pm.<br>-There was no documentation Sodium Chloride was administered on 09/01/24 through 09/03/24.<br>-There was a computerized entry for Ketotifen 0.025%, 1 drop to be administered into each eye | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 61 | C 341 | | |

in the morning and at bedtime and scheduled for 8:00am and 8:00pm.
-There was no documentation Ketotifen 0.025% was administered on 09/01/24 through 09/03/24.
-There was a computerized entry for Trazodone 100mg, 2 tablets to be administered each night at bedtime and scheduled for 8:00pm.
-There was no documentation Trazodone 100mg, 2 tablets was administered on 09/01/24 through 09/03/24.
-There was a computerized entry for Haldol 10mg, 2 tablets to be administered each night at bedtime and scheduled for 8:00pm.
-There was no documentation Haldol 10mg, 2 tablets was administered on 09/01/24 through 09/04/24.
-There was a computerized entry for Ciclopirox 8% to be applied to the right great toe each morning and scheduled for 8:00am.
-There was no documentation Ciclopirox 8% was applied on 09/01/24 through 09/04/24.

Second review of Resident #2's medication administration record (MAR) for September 2024 on 09/05/24 revealed:
-There was documentation Haldol 10mg was administered 8:00am on 09/01/24 through 09/05/24.
-There was documentation Linzess 290 mcg was administered at 8:00am on 09/01/24 through 09/05/24.
-There was documentation Multivitamin with minerals was administered 8:00am on 09/01/24 through 09/05/24.
-There was documentation Benztropine 1mg was administered at 8:00am on 09/01/24 through 09/04/24 and 8:00pm on 09/01/24 through 09/04/24.
-There was a computerized entry for Lithium Carbonate 300mg to be administered twice daily

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 62 | C 341 | | |

with food and scheduled for 8:00am and 8:00pm.
-There was documentation Lithium Carbonate 300mg was administered at 8:00am on 09/01/24 through 09/05/24 and at 8:00pm on 09/01/24 through 09/04/24.
-There was documentation Lithium Carbonate 300mg was administered at 8:00am on 09/01/24 through 09/05/24 and at 8:00pm on 09/01/24 through 09/04/24.
-There was documentation Sodium Chloride was administered on 8:00am on 09/01/24 through 09/05/24 and at 5:00pm on 09/01/24 through 09/04/24.
-There was documentation Ketotifen 0.025% was administered on at 8:00am on 09/04/24 through 09/05/24 and at 8:00pm on 09/01/24 through 09/04/24.
-There was documentation Trazodone 100mg, 2 tablets were administered at 8:00pm on 09/01/24 through 09/04/24.
-There was documentation Haldol 10mg, 2 tablets were administered at 8:00pm on 09/01/24 through 09/04/24.
-There was documentation Ciclopirox 8% was applied at 8:00am on 09/01/24 through 09/05/24.

Attempted interview with the medication aide (MA) on 09/05/24 at 1:55pm was unsuccessful.

Refer to interview with the pharmacist for the facility's contracted pharmacy on 09/04/24 at 2:09pm.

Refer to interview with the Administrator on 09/04/24 at 8:50am.

Refer to second interview with the Administrator on 09/05/24 at 10:44am.

3. Review of Resident #3's current FL-2 dated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 63<br><br>09/21/23 revealed:<br>-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, borderline intellectual functioning, and hearing loss.<br>-The resident was ambulatory and constantly disoriented.<br>-There was an order for Fish Oil 1,000mg to be administered at 8:00am every morning. (Fish oil is a medication help reduce pain and swelling.)<br>-There was an order for Tylenol 500mg Extra Strength to be administered at 8:00am every morning. (Tylenol Extra Strength is a medication used to treat pain).<br>-There was an order for Vitamin D3 1,000 units, take one tablet every morning (Vitamin D3 is a medication used to help maintain healthy bones).<br>-There was an order for Cogentin 0.5mg, take one tablet twice a day at 8:00am and 8:00pm (Cogentin is a mediation used to treat tremors).<br>-There was an order for Azelastine 0.1% nasal spray; spray two sprays into both nostrils twice a day (Azelastine is a medication used to treat hay fever).<br>-There was an order for Depakote ER 500mg, take 4 tablets (2,000mg), at bedtime (Depakote is a medication used to treat mood disorders).<br>-There was an order for Invega Trinza 410 mg/1.32 ml, inject 410 mg intramuscularly every 12 weeks (Invega Trinza is a medication used to treat schizophrenia).<br>-There was an order for Albuterol HFA 90mcg inhaler; inhale 2 puffs by mouth every 6 hours as needed for wheezing or shortness of breath (Albuterol is a medication used to treat wheezing and difficulty breathing).<br><br>Review of Resident #3's psychiatrist visit note dated 07/08/24 revealed there was an order for Lorazepam 1mg tablet, take one tablet twice a | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 64 | C 341 | | |

day at 8:00am and 8:00pm (Lorazepam is a medication used to treat anxiety).

Review of Resident #3's medication administration record (MAR) for September 2024 on 09/04/24 revealed:
-There was a printed entry for Fish Oil 1,000mg to be administered daily at 8:00am.
-There was no documentation Fish Oil 1,000mg was administered each morning at 8:00am from 09/01/24 through 09/04/24.
-There was a printed entry for Tylenol 500mg Extra Strength to be administered daily at 8:00am.
-There was no documentation Tylenol 500mg Extra Strength was administered each morning at 8:00am from 09/01/24 through 09/04/24.
-There was a printed entry for Vitamin D3 1,000 units to be administered daily at 8:00am.
-There was no documentation Vitamin D3 1,000 units was administered each morning at 8:00am from 09/01/24 to 09/04/24.
-There was a printed entry for Cogentin 0.5mg to be administered daily at 8:00am and 8:00pm.
-There was no documentation Cogentin 0.5mg was administered daily at 8:00am and 8:00pm from 09/01/24 to 09/03/24.
-There was a printed entry for Azelastine 0.1% nasal spray, to be administered into both nostrils twice a day at 8:00am and 8:00pm.
-There was no documentation Azelastine 0.1% nasal spray was administered daily at 8:00am and 8:00pm from 09/01/24 to 09/03/24.
-There was a printed entry for Depakote ER 500mg, take 4 tablets (2,000mg) at 8:00pm.
-There was no documentation Depakote ER 500mg was administered daily at 8:00 pm from 09/01/24 to 09/03/24.
-There was a printed entry for Albuterol HFA 90mcg inhaler; inhale 2 puffs by mouth every 6

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 65<br>hours as needed.<br>-There was no documentation Albuterol HFA 90mcg inhaler was administered every 6 hours as needed from 09/01/24 to 09/04/24.<br>-There was a printed entry for Lorazepam 1mg to be administered at 8:00am and 8:00pm for anxiety.<br>-There was no documentation Lorazepam 1mg was administered at 8:00am and 8:00pm from 09/01/24 to 09/04/24.<br><br>Second review of Resident #3's MAR for September 2024 on 09/05/24 revealed:<br>-There was a printed entry for Fish Oil 1,000mcg to be administered daily at 8:00am.<br>-There was documentation Fish Oil 1,000mg was administered each morning at 8:00am from 09/01/24 to 09/04/24.<br>-There was a printed entry for Tylenol 500mg Extra Strength to be administered daily at 8:00am.<br>-There was documentation Tylenol 500mg Extra Strength was administered at 8:00am from 09/01/24 through 09/04/24.<br>-There was a printed entry for Vitamin D3 1,000 units to be administered daily at 8:00am.<br>-There was documentation Vitamin D3 1,000 units was administered at 8:00am from 09/01/24 to 09/04/24.<br>-There was a printed entry for Cogentin 0.5mg to be administered daily at 8:00am and 8:00pm.<br>-There was documentation Cogentin 0.5mg was administered daily at 8:00am and 8:00pm from 09/01/24 to 09/04/24.<br>-There was a printed entry for Azelastine 0.1% nasal spray, to be administered into both nostrils twice a day at 8:00am and 8:00pm.<br>-There was documentation Azelastine 0.1% nasal spray was administered daily at 8:00am and 8:00pm from 09/01/24 to 09/04/24. | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 66<br>-There was a printed entry for Depakote ER 500mg, take 4 tablets (2,000mg) at 8:00pm.<br>-There was documentation Depakote ER 500mg was administered daily at 8:00 pm from 09/01/24 to 09/04/24.<br>-There was a printed entry for Albuterol HFA 90mcg inhaler; inhale 2 puffs by mouth every 6 hours as needed.<br>-There was no documentation Albuterol HFA 90mcg inhaler was administered every 6 hours as needed from 09/01/24 to 09/04/24.<br>-There was a printed entry for Lorazepam 1mg to be administered daily at 8:00am and 8:00pm for anxiety.<br>-There was documentation Lorazepam 1mg was administered at 8:00am and 8:00pm from 09/01/24 to 09/04/24.<br><br>Attempted interview with the medication aide (MA) on 09/05/24 at 1:55pm was unsuccessful.<br><br>Refer to interview with the pharmacist for the facility's contracted pharmacy on 09/04/24 at 2:09pm.<br><br>Refer to interview with the Administrator on 09/04/24 at 8:50am.<br><br>Refer to second interview with the Administrator on 09/05/24 at 10:44am.<br><br>4. Review of Resident #4's current FL-2 dated 01/29/24 revealed:<br>-Diagnoses included intellectual disabilities, schizoaffective disorder bipolar type, and hyperlipidemia.<br>-The resident was ambulatory and constantly disoriented.<br>-There was an order for Fenofibrate 145mcg to be administered at 8:00pm every evening | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 67<br>(Fenofibrate is a medication used to treat high cholesterol).<br>-There was an order for Ezetimibe 10mg to be administered at 8:00pm every evening (Ezetimibe is a medication used to treat cholesterol).<br>-There was an order for Invega Sustenna inject 1ml=156 mg/ml intramuscular every four weeks (Invega Sustenna is a medication used to treat schizophrenia).<br>-There was an order for Olanzapine 20mg to be administered at 8:00pm every evening (Olanzapine is a medication used to treat psychosis).<br>-There was an order for Olanzapine 5mg to be administered at 8:00pm every evening.<br>-There was an order for Omeprazole 20mg to be administered every morning after breakfast at 9:00am (Omeprazole is a medication used to treat indigestion).<br>-There was an order for Valproic Acid 250mg; take 3 capsules (750mg) at 8:00am and 8:00pm every day for mood stabilization (Valproic Acid is a medication used to treat bipolar disorder).<br>-There was an order for Trazodone 50mg, take one tablet every night at 8:00pm (Trazodone is a medication used to treat insomnia).<br>-There was an order for Melatonin 10mg, take one tablet every night at 8:00pm (Melatonin is a medication used to treat insomnia).<br><br>Review of a dermatologist order for Resident #4 dated 08/20/24 revealed:<br>-There was an order for Hydrocortisone 2.5% ointment, apply topically on face daily for rash or skin irritation, 2 days on and 2 days off, do not apply on days when using Nystatin.<br>-There was an order for Nystatin 100,000 unit/gram, apply topically to face daily for rash, 2 days on, then 2 days off, alternating with Hydrocortisone 2.5% ointment. | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 68<br><br>Review of Resident #4's medication administration record (MAR) for September 2024 on 09/04/24 revealed:<br>-There was a printed entry for Fenofibrate 145mcg to be administered daily at 8:00am.<br>-There was no documentation Fenofibrate 145mcg was administered each morning at 8:00am from 09/01/24 through 09/04/24.<br>-There was a printed entry for Olanzapine 20mg to be administered at 8:00pm every evening.<br>-There was no documentation that Olanzapine 20mg was administered from 09/01/24 through 09/03/24.<br>-There was a printed entry for Olanzapine 5mg to be administered at 8:00pm every evening.<br>-There was no documentation that Olanzapine 5mg was administered from 09/01/24 through 09/03/24.<br>-There was a printed entry for Valproic Acid 250mg, take 3 capsules (750mg) at 8:00am and 8:00pm every day.<br>-There was no documentation that Valproic Acid 250mg was administered from 09/01/24 through 09/04/24 at 8:00am and 09/01/24 through 09/03/24 at 8:00pm.<br>-There was a printed entry for Trazodone 50mg, take one tablet every night at 8:00pm.<br>-There was no documentation that Trazodone 50mg was administered from 09/01/24 through 09/03/24.<br>-There was a printed entry for Melatonin 10mg, take one tablet every night at 8:00pm.<br>-There was no documentation that Melatonin 10mg was administered from 09/01/24 through 09/03/24.<br>-There was a printed entry for Hydrocortisone 2.5% ointment, apply topically on face daily for rash or skin irritation at 8:00am, 2 days on and 2 days off, do not apply on days when using | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ____ B. WING ____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 69<br>Nystatin.<br>-There was no documentation that Hydrocortisone 2.5% ointment was administered at 8:00am from 09/01/24 through 09/04/24.<br>-There was a printed entry for Nystatin 100,000 unit/gram, apply topically to face daily for rash at 8:00am, 2 days on, then 2 days off, alternating with Hydrocortisone 2.5% ointment.<br>-There was no documentation that Nystatin 100,000 unit/gram was administered at 8:00am from 09/01/24 through 09/04/24.<br><br>Second review of Resident #4's MAR for September 2024 on 09/05/24 revealed:<br>-There was a printed entry for Fenofibrate 145mcg to be administered daily at 8:00am.<br>-There was documentation Fenofibrate 145mcg was administered each morning at 8:00am from 09/01/24 to 09/04/24.<br>-There was a printed entry for Ezetimibe 10mg to be administered at 8:00pm every evening.<br>-There was documentation Ezetimibe 10mg was administered every evening at 8:00pm from 09/01/24 through 09/04/24.<br>-There was a printed entry for Olanzapine 20mg to be administered at 8:00pm every evening.<br>-There was documentation that Olanzapine 20mg was administered every evening at 8:00pm from 09/01/24 through 09/04/24.<br>-There was a printed entry for Olanzapine 5mg to be administered at 8:00pm every evening.<br>-There was documentation that Olanzapine 5mg was administered every evening at 8:00pm from 09/01/24 through 09/04/24.<br>-There was a printed entry for Valproic Acid 250mg, take 3 capsules (750mg) at 8:00am and 8:00pm every day.<br>-There was documentation that Valproic Acid 250mg, take 3 capsules (750mg) was administered at 8:00am and 8:00pm from | C 341 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 70<br>09/01/24 through 09/04/24.<br>-There was a printed entry for Trazodone 50mg, take one tablet every night at 8:00pm.<br>-There was documentation that Trazodone 50mg was administered every evening at 8:00pm from 09/01/24 through 09/04/24.<br>-There was a printed entry for Melatonin 10mg, take one tablet every night at 8:00pm.<br>-There was documentation that Melatonin 10mg was administered every evening at 8:00pm from 09/01/24 through 09/04/24.<br>-There was a printed entry for Hydrocortisone 2.5% ointment, apply topically on face daily for rash or skin irritation, 2 days on and 2 days off, do not apply on days when using Nystatin.<br>-There was documentation that Hydrocortisone 2.5% ointment was applied at 8:00am on 09/01/24 and 09/04/24.<br>-There was a printed entry for Nystatin 100,000 unit/gram, apply topically to face daily for rash, 2 days on, then 2 days off, alternating with Hydrocortisone 2.5% ointment.<br>-There was documentation that Nystatin 100,000 unit/gram was applied at 8:00am on 09/01/24 and 09/04/24.<br><br>Attempted interview with the medication aide (MA) on 09/05/24 at 1:55pm was unsuccessful.<br><br>Refer to interview with the pharmacist for the facility's contracted pharmacy on 09/04/24 at 2:09pm.<br><br>Refer to interview with the Administrator on 09/04/24 at 8:50am.<br><br>Refer to second interview with the Administrator on 09/05/24 at 10:44am.<br>______________________________<br>Interview with the pharmacist for the facility's | C 341 | | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 71 | C 341 | | |

contracted pharmacy on 09/04/24 at 2:09pm revealed:
-They entered medications orders onto the medication administration records (MARs) and sent the eMAR to the facility each month.
-MARs were usually sent towards the end of each month approximately 1 week prior to the beginning of the next month.
-The MARS for September 2024 were sent the facility on 08/23/24 and would have been available for documentation on 09/01/24.

Interview with the Administrator on 09/04/24 at 8:50am revealed:
-The handwritten note was left by the medication aide (MA) that morning on 09/04/24.
-The MA would document the administration of medications to the residents later in the day.
-The facility had not received printed MARS from the facility's contracted pharmacy the before 09/01/24.
-She and the MA should have created a handwritten MAR to use until the MAR from the pharmacy was received.

Second interview with the Administrator on 09/05/24 at 10:44am revealed:
-The MARs were not available for the MA to document the administration of medications to the residents on 09/01/4 through 09/03/24.
-The MARs came from the pharmacy and did not arrive at the facility until the evening of 09/03/24 and they were available for documenting the medications administered on the morning of 09/04/24.
-The MA documented the medications she administered on a sheet of paper and documented the administration of medications for each resident on 09/04/24 when she returned to the facility later that day.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 341 | Continued From page 72<br>-Medications should have been documented at the time of administration but staff did not do what they were supposed to do. | C 341 | | |
| C 342 | 10A NCAC 13G .1004(j) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records (MARS) for 2 of 4 residents (#1, and #4) including a nutritional supplement (#1) and a medication for constipation (#4).<br><br>The findings are: | C 342 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 342 | Continued From page 73 | C 342 | | |

1. Review of Resident #1's current FL-2 dated 08/13/24 revealed:
-Diagnoses included schizoaffective disorder bipolar type, delusional disorder, hyperthyroidism and asthma.
-He was constantly disoriented.
-There was an order for nutritional supplement drink; one can to be administered every day.

Observation of the refrigerator on 09/05/24 at 10:44am revealed there were no nutritional supplement available for Resident #1.

Review of Resident #1's electronic medication administration record (eMAR) for September 2024 on 09/04/24 revealed:
-There was a computerized entry for nutritional supplement with instructions to drink one can every day for supplement and was scheduled for 8:00am.
-There was no documentation nutritional supplement was administered.

Review of Resident #1's eMAR for September 2024 on 09/05/24 revealed:
-There was a computerized entry for nutritional supplement with instructions to drink one can every day for supplement and was scheduled for 8:00am.
-There was documentation nutritional supplement was administered each day on 09/01/24 through 09/05/24.

Interview with Resident #1 on 09/04/24 at 10:30am revealed:
-He finished a 24 pack of nutritional supplement drinks approximately 5 days or so ago and did not have any more.
-He drank them 3 times a day when they were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 342 | Continued From page 74<br>available.<br><br>Telephone interview with pharmacist with the facility's contracted pharmacy on 09/05/24 at 2:00pm revealed:<br>-The pharmacy provided the nutritional supplement as a supplement for nutritional support for Resident #1.<br>-A 24 pack of nutritional supplement drinks for Resident #1 was last dispensed on 08/14/24.<br>-Staff were required to request the supplement for Resident #1 each time it was need and there had been no request for a refill.<br><br>Interview with the Administrator on 09/05/24 at 10:44am revealed:<br>-There were no nutritional supplement available for Resident #1.<br>-They were stored in the refrigerator when they were available, and Resident #1 would get them out 3 times a day.<br>-He was told he was ordered to have 1 each day but Resident #1 did not listen.<br>-She was not aware there were no nutritional supplement drinks available, and she did not know if staff had ordered more from the pharmacy.<br>-She did not know what should have happened to ensure the supplement was available for Resident #1.<br>-The supplement should not have been documented as administered when it was not available to be administered.<br><br>Attempted telephone interview with Resident #1's primary care provider on 09/05/24 at 3:15pm was unsuccessful.<br><br>2. Review of Resident #4's current FL-2 dated 01/29/24 revealed: | C 342 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| A CHILD'S HOPE FAMILY CARE HOME | 329 PARK AVENUE ROCKY MT, NC 27801 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 342 | Continued From page 75 | C 342 | | |

-Diagnoses included intellectual disabilities, schizoaffective disorder bipolar type, and hyperlipidemia.
-The resident was ambulatory and constantly disoriented.
-There was an order for Linzess 72 MCG, take one capsule at 8:00am with a full glass of water (Linzess is a medication used to treat constipation).

Review of a signed physician order for Resident #4 dated 06/10/24 revealed there was a discontinue order for Linzess.

Review of Resident #4's medication administration record (MAR) for August 2024 revealed:
-There was a printed entry for Linzess 72 MCG, take one capsule at 8:00am with a full glass of water every morning.
-There was documentation Linzess 72 MCG was administered at 8:00am from 08/09/24 through 08/31/24.

Review of Resident #4's MAR for September 2024 on 09/04/24 revealed:
-There was a printed entry for Linzess 72 MCG, take one capsule at 8:00am with a full glass of water every morning.
-There was no documentation Linzess 72 MCG was administered at 8:00am from 09/01/24 through 09/04/24.
-There was a handwritten entry on the MAR with "D/C," discontinue.

Interview with Resident #4 on 09/05/24 at 9:15 revealed he had not experienced difficulties with constipation or loose stools in the past few weeks.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL033016 | A. BUILDING: ______ B. WING ______ | R-C **09/06/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **A CHILD'S HOPE FAMILY CARE HOME** | **329 PARK AVENUE ROCKY MT, NC 27801** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| C 342 | Continued From page 76 | C 342 | | |

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/05/24 at 2:00pm revealed:
-There was an order for Linzess 72 MCG, take one capsule at 8:00am with a full glass of water every morning.
-Linzess 72 MCG was dispensed for Resident #4 on 10/26/22 for a quantity of 30 pills, to take one capsule every day at 8:00am for a 30-day supply.

Observations of medications on hand on for Resident #4 on 09/05/24 at 10:06am revealed there were no Linzess 72 MCG capsules available.

Interview with the Administrator 09/06/24 at 1:30pm revealed:
-She was not sure why she documented on the August 2024 MAR from 08/09/24 to 08/31/24 that she administered Resident #4 Linzess.
-There was no Linzess in the facility for Resident #4 since his discontinue order in June 2024.
-It was her mistake not to notify the pharmacy to remove the entry for Linzess to be administered daily to Resident #4.

Attempted telephone interview with Resident #4's primary care provider on 09/05/24 at 2:10pm was unsuccessful.