Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                         | (X3) DATE SURVEY<br>COMPLETED  |            |                          |
|---|--|--|-------------------------|--|------------|--------------------------|
|   |  | MHL092-950   | B. WING                 |  | R<br>11/13 | 3/2019                   |
| NAME OF I   | PROVIDER OR SUPPLIER   |  | DRESS, CITY, S          | STATE, ZIP CODE  | 1          |                          |
| ABUNDA  | ANT GRACE FAMILY O   | CARE HOME INC  | LAN DRIVE<br>, NC 27606 |  |            |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE      | (X5)<br>COMPLETE<br>DATE |
| V 000   | INITIAL COMMENT  | TS .   | V 000                   |  |            |                          |
|   | completed on Nove<br>(Intake #NC001560<br>Deficiencies were of<br>This facility is license   | sed for the following service<br>C 27G .5600A Supervised   |                         |  |            |                          |
| V 118   | 27G .0209 (C) Med  | ication Requirements   | V 118                   |  |            |                          |
|   | only be administered order of a person andrugs.  (2) Medications shat clients only when and client's physician.  (3) Medications, include administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered all drugs administer current. Medication recorded immediated MAR is to include the (A) client's name;  (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug.  (5) Client requests the corder of a person of a person or a person of a person | inistration: non-prescription drugs shall and to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be any licensed persons, or by a trained by a registered nurse, are legally qualified person and the and administer medications. Iministration Record (MAR) of a to each client must be kept as administered shall be the ley after administration. The |                         |  |            |                          |

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

(X6) DATE TITLE

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE  |            | ,                   | E CONSTRUCTION  |           | SURVEY<br>PLETED         |
|--|---|--|------------|---------------------|---|-----------|--------------------------|
|  |   |  |            | 7 L BOILBING.       |   |           | R                        |
|  |   | MHL092-950   |            | B. WING             |   |           | 13/2019                  |
| NAME OF  | PROVIDER OR SUPPLIER  | ST   | REET ADD   | DRESS, CITY, S      | STATE, ZIP CODE   |           |                          |
| ABUNDA   | ANT GRACE FAMILY  | CARE HOME INC  |            | NC 27606            |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FUL<br>SC IDENTIFYING INFORMATION   |            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| V 118  | , , , , , , , , , , , , , , , , , , ,   | age 1<br>appointment or consultat  | tion       | V 118               |   |           |                          |
|  | Based on record refailed to assure state administer medicate medications were a authorization of a publication of the clients (#1, #4, #6), one of three audite administered medications. | et as evidenced by: eview and interview, the fift demonstrated skills to tions as well as assure administered on written ohysician for three of three . The facility failed to ass d clients (#4) who self cations had written ysician. The findings are | ee<br>sure |                     |   |           |                          |
|  | the following: -Admitted: -Diagnoses: So (Gastroesophagea)  | 9 of client #1's record rev<br>chizophrenia, Diabetes, (<br>I Reflux Disease), High<br>tension, Hyponatremia a<br>lipsia   | GERD       |                     |   |           |                          |
|  | the following: -Admitted: 08/1 -Diagnoses: So   | chizophrenia, Sleep Apno<br>Blaucoma and Chronic   |            |                     |   |           |                          |
|  | the following: -Admitted: 04/1 -Diagnoses: So<br>Bilateral Amputatio  | 9 of client #6's record rev<br>19/16<br>chizophrenia (Paranoid T<br>n, Diabetes Types 2,<br>erlipidemia, Obesity, Ane  | Гуре),     |                     |   |           |                          |

Division of Health Service Regulation

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:  | E CONSTRUCTION            | (X3) DATE SURVEY<br>COMPLETED  |               |                         |
|--|--|---|---------------------------|--|---------------|-------------------------|
|  |  | MHL092-950  | B. WING                   |  | R<br>11/13/20 | )19                     |
|  | PROVIDER OR SUPPLIER   | CARE HOME INC 5040 KAR  | DDRESS, CITY, SPLAN DRIVE | STATE, ZIP CODE  |               |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE CO      | (X5)<br>DMPLETE<br>DATE |
|  | revealed:     -Hired: 06/08/19  I. Staff competency administration  During interview on clients revealed:     -Their individua their assigned seat mealtime.  During interview on  | of staff #1's personnel record  |                           |  |               |                         |
|  | served as a live in  -The following a administration: obta from their bubble pa placed inside their s pill counter placed a dinner table before took their medication  During interview on Professional reporte  -She would hav obtain the medication and staff not followin medications  II. Physician's order  Review on 11/04/19 the following:  -Admission Ass | as his process for medication ained medications for clients ackets or bottlesmedication single dosage pill counter at client's designated seat at the clients arrivedclients ons.  11/12/19, the Qualified ed: re concerns clients could ons of a peer, not monitored and protocol of administering reto self administer medication of client #4's record revealed ressment noted he had been |                           |  |               |                         |
|  |  | years at a state supported  |                           |  |               |                         |

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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |  | (X1) PROVIDER/SUPFIDENTIFICATION   |   | ` '                     | E CONSTRUCTION   | (X3) DATE<br>COME | SURVEY<br>PLETED         |  |  |  |
|--|--|--|---|-------------------------|--|-------------------|--------------------------|--|--|--|
|  |  |  |   | 71. 501251110.          |  |                   | ٦                        |  |  |  |
|  |  | MHL092-950   |   | B. WING                 |  |                   | 3/2019                   |  |  |  |
| NAME OF PROVIDER OR S  | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |  |   |                         |  |                   |                          |  |  |  |
| ABUNDANT GRACE F   | AMILY  | CARE HOME INC  |   | LAN DRIVE<br>, NC 27606 |  |                   |                          |  |  |  |
| PREFIX (EACH DE  | FICIENC  | ATEMENT OF DEFICIENCY<br>Y MUST BE PRECEDED<br>SC IDENTIFYING INFOR  | BY FULL   | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION OF<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE         | (X5)<br>COMPLETE<br>DATE |  |  |  |
| 60 units at r -No phy -Septen initials to ind  During inter client #4 an administere indicated he administer t did not reca administer t  During inter Professiona -She wa physician's -Per the with his med they trained physician's -Within order had b  III. No physi  a. Review b client #4's ra -Septen initials Zyrte (used for tra Fluticasone (used for us tablet daily of Alvesco 80 prevent astr -No phy | view be defined to the insurance of the insurance of the insurance of the past defined in the insurance of the past defined in the insurance of the past dication of the past dic | 15/19 for Lantus Sisulin for Diabetes) orders to self adnovember 2019 MAI antus  Etween 11/08/19 are 17/17/19 the Quantum 11/12/19, the Quantum 11/12/19, the Quantum 15/19/19/19/19/19/19/19/19/19/19/19/19/19/ | ninister R noted  ad 11/12/19, 44 self Client #4 7 to o." Client #4 self alified a sulin. dependent of sure if provide a nister insulin ohysician's ned ons 2/19 of ving: Rs noted tablet daily ms), ostril daily min D3 one cy) and used to stered | V 118                   |  |                   |                          |  |  |  |

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

| NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   SAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   SAME ARPLAN DRIVE   RALEIGH, NC 27666   SAME ARPLAN DRIVE   COMMENTATION   PREPENT   COMMENT |           | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING:                                  |                |  | (X3) DATE SURVEY<br>COMPLETED  |          |
|--|-----------|---|--|---|----------------|--|--------------------------------|----------|
| ABUNDANT GRACE FAMILY CARE HOME INC  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGOLATORY OR LSC IDENTIFYING INFORMATION)  V118  Continued From page 4  b. Review between 11/04/19 and 11/12/19 of client #6's records revealed the following -September-November 2019 MARs noted initials Tiroot 148 fm gone tablet daily (used for treatment of hyperlipidemia) was administered -No physician's order on file for Tiroor  c. Review between 11/04/19 and 11/12/19 of client #1's records revealed the following: -September-November 2019 MARs noted initials Cozaar 50 mg one tablet daily (used for treatment of hyperlepidemia) was administered -No physician's order on file for Tiroor  During interview on 11/12/19, the Qualified Professional reported the following: -Verified the above missing physician's orders noted for clients #1, #4 and #6  -Agency process was to obtain orders from physicians either through consultation forms or from copies of the doctor's visits -Acknowledged overall medication system may need to be reviewed with staff  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.  V 738  27G .0303(d) Pest Control  V 738  V 738 27G .0303(d) Pest Control  V 738   |           |   | MHL092-950   |   | B. WING        |  |                                |          |
| CALIFICATION   CALI | NAME OF F | PROVIDER OR SUPPLIER  | Ş  | STREET ADD  | DRESS, CITY, S | STATE, ZIP CODE                                |                                |          |
| CA1D   SUMMARY STATEMENT OF DEFICIENCIES   PRETEX   GACH OPRECIDENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   GACH OPRECIDENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   V 118   | ABUNDA    | NT GRACE FAMILY O   | CARE HOME INC  |   |                |  |                                |          |
| b. Review between 11/04/19 and 11/12/19 of client #6's records revealed the following  | PREFIX    | (EACH DEFICIENCY  | MUST BE PRECEDED BY FL   |   | PREFIX         | (EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T | ON SHOULD BE<br>HE APPROPRIATE | COMPLETE |
|  |           | b. Review between client #6's records in September-No initials Tricor 145 m treatment of hyperling-No physician's c. Review between client #1's records in September-No initials Cozaar 50 m treatment of hypertitablet daily (used to No physician's Lipitor.  During interview on Professional reporting September-No initials Cozaar 50 m treatment of hypertitablet daily (used to No physician's Lipitor.  During interview on Professional reporting the about of clients #1 September-No initials Cozaar 50 m treatment of hypertitablet daily (used to No physician's Lipitor.  During interview on Professional reporting the about of the control | a 11/04/19 and 11/12/19 revealed the following ovember 2019 MARs nowember 2019 MARs nowember 2019 mas administ order on file for Tricor 11/04/19 and 11/12/19 revealed the following: ovember 2019 MARs nowember 2019 mas nowember 2 | oted d for tered  of oted d for mg one aar and d s orders s from ms or stem |                |  |                                |          |

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Division of Health Service Regulation

|                          |  | (X1) PROVIDER/SUPPLIER/<br>IDENTIFICATION NUME   |  | ` '                   | E CONSTRUCTION  |                              | SURVEY<br>PLETED         |
|--------------------------|--|--|--|-----------------------|---|------------------------------|--------------------------|
|                          |  |  |  | A. BOILDING.          |   |                              | R                        |
|                          |  | MHL092-950   |  | B. WING               |   |                              | 13/2019                  |
| NAME OF                  | PROVIDER OR SUPPLIER   | S  | STREET ADI   | DRESS, CITY, S        | STATE, ZIP CODE   |                              |                          |
| ABUNDA                   | ANT GRACE FAMILY   | CARE HOME INC  |  | LAN DRIVE<br>NC 27606 |   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FU<br>SC IDENTIFYING INFORMATION  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| V 738                    | Continued From pa  | age 5  |  | V 738                 |   |                              |                          |
|                          | Based on observat governing body fail kept free from inse Observations between revealed fruit flies f dining room area d of fruit sitting out or Estimated more that During interviews b staff #1 reported:  -He apologized towel to scatter the -Not sure why files in the kitchen/l -When he oper entered the facility During interview on Professional report -Due to comprecould not see the fruit remained at the fact -She was not a fruit flies and quest the fruit flies, how lead to see the fruit flies and quest the flies and | een 11/04/19- 11/12/19 flying around in the kitcl uring each visit. No evid trash piled up in a trast an 10-20 fruit flies in the petween 11/04/19-11/12 If for the fruit flies and u m away, the facility had so many living room area hed the back door, fruit an 11/12/19, the Qualified ed: comised eyesight, intially ruit flies. However, she w t flies consistently as sh | hen and dence sh can. e area.  2/19, sed a / fruit flies  d //, she was ne ne the rigin of in the al |                       |   |                              |                          |

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