	of Health Service Regu FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SUF	31/EY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	
		MHL0411118	8. WING		R 06/30/	2021
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
WATLING	TON'S FAMILY CARE HO	MES #3	ERROD-WATLINGT BBORO, NC 27406	* *		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE	(X6) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An Annual and Follow on 6/30/21. A deficier	v-Up Survey was completed ncy was cited.	***************************************		######################################	
		d for the following service 27G .5600C: Supervised ntally Disabled Adults				
V 367	27G .0604 Incident R	eporting Requirements	V 367		Terrocco-Opport management	
	level II incidents, excet the provision of billable consumer is on the principal provision of billable consumer is on the principal provider. The provider services are provided becoming aware of the exception of the submitted on a form secretary. The report in person, facsimile or means. The report shinformation: (1) reporting providentification information: (2) client identification information: (3) type of inciding type of inciding type of inciding type of inciding type of the cause of the incident; (6) other individing or responding. (b) Category A and B missing or incomplete	REMENTS FOR PROVIDERS providers shall report all pot deaths, that occur during e services or while the oviders premises or level III deaths involving the clients rendered any service within cident to the LME tehment area where within 72 hours of e incident. The report shall m provided by the may be submitted via mail, e encrypted electronic hall include the following ovider contact and on; cation information; ent; of incident; effort to determine the				
	th Service Regulation RECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURI	=	TITLE	(xa) DATE
E FORM	mue Wa	tungton	6890 1 000	Ridministrator/OF	8/	26/

administrator/OF

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING:	***************************************	
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
SATANNE SALM	******* ******************************	1401 SHE	RROD-WATLIN	IGTON CIRCLE	
WAILING	TON'S FAMILY CARE HO	MES #3 GREENSE	30RO, NC 274	106	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ĺD	PROVIDER'S PLAN OF CORRECT	TION (X6)
PREFIX TAG		/ MUST BE PRECÉDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
V 367	Continued From page	1	V 367		
	report recipients by th	e end of the next business			
	day whenever:		***************************************		
		has reason to believe that	***************************************		****
	information provided i				
		or otherwise unreliable; or			
		obtains information			
	· · · · · · · · · · · · · · · · · · ·	nt form that was previously			
	unavailable.	providers shall submit.		·	***************************************
	upon request by the L	•		***************************************	
	obtained regarding the	· · · · · · · · · · · · · · · · · · ·		***************************************	
		ords Including confidential			
	information;	•		***************************************	
	(2) reports by of	ther authorities; and		7-44	
		s response to the incident.		***************************************	The second secon
		providers shall send a copy		Table Control of the	0000
		reports to the Division of		***************************************	
		pmental Disabilities and			
		vices within 72 hours of incident. Category A		Na accounter	**************************************
	providers shall send a			A A A A A A A A A A A A A A A A A A A	
		llent death to the Division of		***	
	Health Service Regula			***************************************	
	becoming aware of the	incident. In cases of		***************************************	
	client death within sev	en days of use of seclusion		44 addition	
		er shall report the death		rinasa a sanara a sa	
	immediately, as requir			sereza	
	.0300 and 10A NCAC			Vocata	
	(e) Category A and B	•		obovoranja i sa	
		LME responsible for the		Months	
		services are provided. omitted on a form provided		***************************************	
		ectronic means and shall			
	include summary infor			**************************************	
		mors that do not meet the			
	definition of a level II o	· · · · · · · · · · · · · · · · · · ·			
	(2) restrictive int	erventions that do not meet			
	the definition of a level				***************************************
	(3) searches of a	a client or his living area;			To the second

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411110	8. WING		R 06/30/2021	
NAME OF D	RÓVIDER OR SUPPLIER	OTOEET A	Norde dev et	ATT TO CORE	4412412421	
NAME OF F	MOVIDER OR SUPPLIER		DDRESS, CITY, ST	NGTON CIRCLE		
WATLING	TON'S FAMILY CARE HO	MES #3	BORO, NC 274			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	(D	PROVIDER'S PLAN OF CORRECTION	(X6)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPA DEFICIENCY)	BE COMPLET	re
V 367	Continued From page		V 367			
	the possession of a cl (5) the total nur incidents that occurre (6) a statement been no reportable in incidents have occurre meet any of the criteri	mber of level II and level III id; and i indicating that there have cidents whenever no ed during the quarter that is as set forth in Paragraphs e and Subparagraphs (1)				
	occurred during the pr to the LME (Local Mai hours of becoming aw findings are: Review on 6/28/21 of revealed: - "Name of Resident: [and record review, the all Level II incidents that rovision of billable services nagement Entity) within 72 vare of the incident. The		Plan of Corre Time from for complie Administrator comp TRIS report on 7/3/2/1 File # Administrator reporter Client was transp by ambulance to hos on 11/5/20 and she in hospital on 11/7	etion nce: 7/2/20 leted That orted pital	0 2(
	- "Person filing Report - "As I returned to the observed resident (FC back as she was sitting approached resident a Staff began to pick up wheelchair and put he white mucus coming o	: [Former Staff (FS) #4]" facility at 3:39 pm staff : #6) with her head leaning g in her wheelchair. Staff and observed her sleeping. resident out of her r in bed. Staff observed out of her mouth and nose. Ith a cold compress and		in hospital on 11/2	20.	

Division (of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0411110	B. WING	***************************************	R 06/30/2021
NAME OF B	ROVIDER OR SUPPLIER	V-6-2-4 P			
MANIALE CALLE	ICOAIDEIL OU GÖLLEIEU		DDRESS, CITY, ST	• • • • • • • • • • • • • • • • • • • •	
WATLING	TON'S FAMILY CARE HO	MES #3 GREENS	ERROD-WATLIN BORO, NC 274		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 367	Continued From page realized the resident if (temperature). Staff p with no response. At 1 #1]. [Licensee #1] arri (staff #2) tried to take to listen for a heartbeiresponse. [Licensee #4:12 pm. [FC #6] was Review on 6/30/21 of revealed: - "Arrival Date/Time: 1 - "Chief complaint- ca (Hierarchical Conditio - "5/28/16 ESRD (end dialysis" - "37 y.o. (year old) femedical history including allowers, currently residited ay after being foun known normal at 1430 to make the second property of the second property including a fer being foun known normal at 1430 to make the second property of th	nad "cold" body temp. roceeded to take her vitals 3:52 pm I notified [Licensee ved at 3:59. Another staff vital again. [Staff #2] began at and pulse but still no It] called 911 at around taken to [local hospital]." FC #6's medical record 1/05/2020 1705 (5:05 pm)" rdiac arrest (HCC) n Categories)" stage renal disease) on male with a complex ing dialysis for end-stage re delay, known alcohol ing at a facility presenting diunresponsive with last she had a total of 10 to ardiopulmonary dis of epinephrine given. No or to arrival. She arrives vay in place that was e procedure note with a 7.5 imaging ordered to al hemorrhage, sepsis, Levophed initiated soon maps of 50-60. Patient ow Coma Scale) 3, RSI ation) was not given. No od at this point. Intensivist t show any acule e, the EKG	V 367		the practice: Il report to LME thin ming iculty pletion strator elpline d report n, in ed shuting
	(electrocardiogram) sh (interval seen in an Ek - "Patient presents for arrest. Last known nor	(G)."			

	Division o	of Health Service Regu	lation				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	4 17 11 -4 1 -4 1 4	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE S COMPL	
			MHL0411110	B. WING	***************************************	F 06/3	R 90/2021
Γ	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE ZIP CODE		· ····································
				ERROD-WATLI			
L	WATLING	TON'S FAMILY CARE HO	MES #3 GREENS	BORO, NC 274			
	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(XB) COMPLETE DATE
		her wheelchair. Rhyth fibrillation) with PEA (EMS (emergency me (Cardiopulmonary Rerounds of epinephrine Repeat rhythm was A ventricular response), were lost again, and relation and rise after 7 minute our emergency depart (Glasgow Coma Scale airway in place." "Past Medical Histor Anemia. Bipolar dison disease, Dialysis -M (F (Friday), Cognitive of impairment, Depression without complication (Hyperparathyroldism (Intellectual disability, (arteriovenous) fistula infection)" "Patient Active Problection (Hyperparathyroldism (Intellectual disability, (Interiovenous) fistula infection)" "Patient Active Problection (HCC) - Peripheral vascular of Critical lower limb is peripheral arterial dientical lower limb is peripheral	proup home slumped over In am was asystole, A. fib (atrial pulseless electrical activity). dical services) started CPR suscitation) and gave 3 before return of circulation. fib with RVR (rapid, rate 1 20-1 50. Pulses hythm showed torsades. hore rounds of epinephrine had return of circulation es of circulation return to timent. She arrives GCS a) 3, pulses intact, King y: Alcohol abuse chronic, der (HCC), Chronic kidney Monday), W (Wednesday), changes, Cognitive on, Diabetes mellitus HCC), Elevated lipids, (HCC), Hypertension, Staph aureus infection, A/V and UTI (lower urinary tract em List/Date Noted:) 11/05/2020 chemia 10/21/2020 chemia 10/21/2020 sease (HCC) 09/08/2020 s of toe 09/08/2020 s of toe 09/08/2020 dibt distal tibla 07/22/2020 ad 06/28/2020 co. 020	V 367	A. Measures to preve problem from read of the prevent reaction submit a prelimin entry to create a come back later a in data as collected. 3. Who will monitor si to prevent reoccure hadministrator, is waltington. 4. How often will make place. "Immediately incident occur Administrator is report any a Level II's will ya hours.	telp telp telp thry and fill ted. tence anitonic when when	3
IV		12/12/2019 th Service Regulation				, ,	
		-					

Division of	of Health Service Regu	<u>lation</u>				
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					R	
		MHL0411110	e. WING		06/30	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
I WATEING	TON'S FAMILY CARE HO	ME9 #3	EKKUU-WAILIN	g ion circle		
Astel Pillon		GREENS	BORO, NC 2740	96		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SG IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) 9E	(X6) COMPLETE DATE
V 367	Continued From page	5	V 367			
	07/24/2018 - Mild Intellectual disa - Hyperkalemia 07/31 - Adjustment disorder	/2017 with mixed disturbance of				
}	emotions and conduc					
	Diabetes (HCC) 05/:Essential hypertensi					
	- ESRD on dialysis (H					
	- Pain of left arm 05/2					
	- "Discharge date/time: 11/07/2020 21:07" - "Discharge Disposition: Expired"					
		on: Expired on: Morgue - [local hospital]"			**************************************	
	Review on 6/28/21 of Improvement System	the Incident Response (IRIS) revealed:			mmannocommune A	
	- There was not a rep				We have been seen as the second	
	- On 11/5/20, staff #2 home to relieve FS #4 - Staff #2 was down to she was in her bedrood can't breathe ma." FC because she was the home She went into FC #6	with client #4 revealed: had come to the group for a short period of time. he hall in the staff office and om when FC #6 called out "I #6 called her "ma" oldest client at the group 's bedroom which was				
	beside her bedroom FC #6 asked her to I FC #6's head up for a	nold up her head. She held minute or two, FC #6				
	appeared to be breath asleep. She left FC #6 seemed to be asleep.	ning heavy but seemed to be b's bedroom because "she "				
	returned to the group bedroom. This was wh was unresponsive.	C #6's bedroom, FS #4 had home and went into FC #6's nen FS #4 noticed FC #6				
	THE PERSON OF STREET	ep - with and twite				

Division of Health Service Regulation

		1	(X3) DATE SURVEY COMPLETED		
		MHL0411110	8. WING		R 06/30/2021
NAME OF F	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	ZIP CODE	
WATLING	TON'S FAMILY CARE HO	MFS 323	ERROD-WATLING BORO, NC 27406	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETE
V 367	blood pressure. - FC #4 called the Lic call 911. - The Licensee #1 ha and "started pumping - EMS and the police Interview on 6/29/21 v - On 11/5/20, she had paycheck and stayed with the clients while I paycheck. She staye about 20 minutes. - She had observed F her door open. FC #6 talking to client #4. FC - She overheard FC # tired. Then she heard "what do you want me - She never heard FC breathe. She never sa head. She only saw cl #6 and FC #6 was in I - Soon FS #4 returned - When she was about group home, FS #4 ca something was wrong on the phone that she machine was not work - She drove back to the she arrived at the group plose. FC #6 had no phone with the Licens route to the group hom very quickly. - The Licensee #1 star helped do CPR while the	ensee #1 who told FC #4 to d come into the group home on her (FC #6's) chest." arrived. with staff #2 revealed: come to pick up her for a short period of time FS #4 left to cash her d at the group home for C #6 in her bedroom with was in her wheelchair C #6 "seemed to be fine." 6 tell client #4 she was client #4 say to FC #6 to do?" #6 state she could not lied the	∨ 367		

Division	of Health Service Req	ulation			FORM APPROVED
,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0411110	B. WING		R 06/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	•
	****	1401 SF	IERROD-WATLING		
WAILING	TON'S FAMILY CARE H	OMES #3 GREEN	SBORO, NC 2740	8	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LGC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
V 367	Continued From pag	e 7	V 367		
	Interview on 6/30/21	with FS #4 revealed:			AC-PER SERVICE
	- On 11/5/20 she had asked Licensee #1 If staff				van-
	#2 could come in for	a short period of time and			
		lients while she went to the	haran Assessment Asses		
		#1 granted her permission to	***************************************		
		provided care to the clients.			
	-	out 30 minutes-45 minutes.			WARRY COLOR
	sitting at the kitchen	to the bank, FC #6 was			waarii waa
		, she saw some of the clients			-
		nd one client inside. She			***************************************
		as not at the kitchen table.			**************************************
		aff office and told staff #2 she			- THE PARTY NAME OF THE PARTY
		ft. Then she walked to FC			•
	#6's bedroom.				
		#6 was asleep in her			***
		ried to put FC #6 in bed, 6 in the bed, she noticed FC			4411
		d molst. When she laid FC			***
		nad come out of FC #6's			**************************************
		kept saying [FC #6's name]			****
		had come out of FC #6's			W
	mouth and nose.				4
		ood pressure every morning			
1		ng FC #6's blood pressure.			
		e FC #6's blood pressure but			***************************************
		owing an error. She put the S's heart and did not hear			Month of the state
ĺ	anything.	o realt and did not negr			\$
	• •	nsee #1 who was already in			
		me and about 3 minutes			
	away. She explained	to the Licensee what had	***************************************		
		alled staff #2 who said to	Vancous Vancou		**************************************
	The state of the s) had just left and what	****		***
	could have happened		***************************************		
	- The Licensee called		**************************************		
		for FC #6's heart beat but Ing. The Licensee started	***************************************		
	CPR.	mg. The Enconses statted			
		arrived about 5-6 minutes			
() ()	th Carrier Carrier	A COLUMN TO THE TAXABLE PARTIES AND THE TAXABLE PARTIE			

<u>Division</u>	of Health Service Requ	lation				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O		(X3) DATE S COMPLI	
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					00/3	U/ZUZ!
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
WATLING	TON'S FAMILY CARE HO)MES #3	ERROD-WATLING1 BORO, NC 27406	TON CIRCLE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X6) COMPLETE DATE
V 367	Continued From page	8	V 367			
	died a couple days la - Her CPR training wa 11/5/20 incident She did not make a 11/5/20 incident but d report.	as current at the time of the report to IRIS about the lid write up a level I incident				
	including type 1 diabeth Renai Disease and his times a week. In October 2020, FC grafted from her upper were placed in her low circulation. On 11/4/20, he had appointment and to a doctor did not have all home. He took her to - On 11/5/20, he had it noticed FC #6 did not the group home that a him to bring back her pigs' feet. As he drove back to he received a phone of indicated she could not #6. Upon arrival at the gin her bedroom. FC # had the blood pressur checking for a pulse. He called 911. The 9					
	was able to get FC #6 transporting her to the	til the EMS arrived. EMS 's heart beating prior to hospital.			***************************************	

Division of Health Service Regulation

Division	of Health Service Requ	<u>ilation</u>				
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE		
	which facts are a built to an a pressure a same	1401 SHI		NGTON CIRCLE		
WAILING	TON'S FAMILY CARE HO	JMES #3	BORO, NC 274			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLEY!	Ē
V 367	Continued From page	99	V 367			
	· ***					
		npted to put a report in IRIS				
	twice regarding FC #	o's nospitalization. Staff on 11/6/20 and left a			***************************************	
	message but they ne					
		C #6's death to IRIS.			***	
		e IRIS report) ever showed			•	
	as received. I was ne	ver able to make a copy (of			***	
	the report he typed)."				William Willia	

				***************************************	WATER TO THE TAXABLE PARTY OF TAXABLE PA	
			***		-	- 1
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ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

July 7, 2021

Romulus T. Watlington, Licensee Bonnie Watlington & Romulus Thurman Watlington 1401 Sherrod-Watlington Circle Greensboro, North Carolina 27406

Re: Annual and Follow Up Survey completed June 30, 2021

Watlington's Family Care Homes #3, 1401 Sherrod-Watlington Circle, Greensboro, NC. 27406

MHL # 041-1110

E-mail Address: bwatil222@gmail.com

Dear Mr.. Watlington:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed June 30, 2021.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

All other tags cited are standard level deficiencies.

<u>Time Frames</u> for Compliance

 Standard level deficiency must be corrected within 60 days from the exit of the survey, which is August 29, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.),
- Indicate what measures will be put in place to prevent the problem from occurring again.
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.

Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION NC DEPARTMENT OF HEALTH AND HUMAN SERVICES + DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Releigh, NC 27603 MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718 www.ncdhhs.gov/dhsr • TeL: 919-855-3795 • FAX: 919-715-8078

July 7, 2021 Romulus T. Watlington

Send the <u>original</u> completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Barbara Perdue at (336) 861-6283.

Sincerely,

Angela C. Medlin, MSW

Angela Medlin

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Cc: <u>DHSR_Letters@sandhillscenter.org</u>

Pam Pridgen, Administrative Assistant

200002/0013

PRINTED: 07/02/2021 FORM APPROVED

ID PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	BURVEY
			A. BUILDING;		COMPL	ETED
		MHL0411110	B. WING		F	
ME OF F	PROVIDER OR SUPPLIER	OTAGET			06/3	10/202
			DDRESS, CITY, STATE			
MI LING	TON'S FAMILY CARE	HOMES #3 1401 SH	ERROD-WATLING	TON CIRCLE		
X4) ID	St (Mana A Co	UKEN:	SBORO, NC 27406			
REFIX	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID T	PROVIDER'S PLAN OF CORRECTION	V	***************************************
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD	bs:	(X) COMP
			TAG	CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	RIATE	ÐA
V čán	INITIAL COMMEN	T	_	out recently		- Thilese
	1 MALINE COMMEN	115	V 000			
	An Annual and Fu	función de				
	ON 6/20/24 A Just	low-Up Survey was completed	•			
	on 6/30/21. A defic	ency was cited.				
- 1	Thin families in Itea	uuden ii maa				
	catogon 104 No.	sed for the following service			ļ	
	Living for Double	AC 27G .5600C: Supervised				
İ	riving to Develop.	пentally Disabled Adults				
V 357	27G .0604 Incident	Reporting Requirements	V 367			
					ļ	
	10A NCAC 27G .0	04 INCIDENT				
	REPORTING REQ	UIREMENTS FOR				
	CATEGORYAAND	B PROVIDERS				
İ	(a) Category A and	B providers shall report all				
i i	level II incidents, ex	cept deaths, that occur during				
	the provision of bill	able services or while the			******	
	consumer is on the	providers premises or level III				
1	incidents and level	deaths involving the clients			-	
1	to whom the provide	or rendered any service within				
13	90 days prior to the	incident to the LMF				
1	responsible for the b	atchment area where			***************************************	
1	services are providé	d within 72 hours of			***************************************	
!	becoming aware of	the incident. The report shall				
	oe submitted on a f¢	orm provided by the			VP	
5	secretary. The repe	ort may be submitted via mail,			The second	
1.0	n person, facsimile	or encrypted electronic			-	
r	neans. The report a	shall include the following	Withman		H#0.dh.m	
	ntormation:	-				
	1) reporting p	rovider contact and			****	
10	dentification informa				***************************************	
	2) client ident	ification information;			***************************************	
	3) type of inc					
	4) description	of incident;				
	5) status of th	e effort to determine the	1			
	ause of the incident		-			
(6		duals or authorities notified				
0.0	r responding.					
į (E) Category A and E	providers shall explain any				
, m	ilssing or incomplets	information. The provider				
ls	nali submit an updat	ed report to all required				
Health	Service Regulation 1	SUPPLIER REPRESENTATIVE'S SIGNATURE			1	

administrator/OP

STATE FORM

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE (A. BUILDING;	CONSTRUCTION		S SURVEY PLETED
MAL		MHL0411110	B. WING		0.6	R /30/2004
NAME OF F	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STATI	E 710 000c		/30/2021
WATLING	TON'S FAMILY CAR		SHERROD-WATLING			
			NSBORO, NC 27406	ION CIRCLE		
(X4) ID	SUMMAR	Y STATEMENT OF DECIDIONORS				
PREFIX TAG	REGULATORY	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHALL DE	(X5) COMPLETE DATE
V 367	Continued From p	age 1	V 367			
	report recipients H	to the and at u.	1			
	day whenever:	y the end of the next business	-			
	"	der has reason to believe that	***			
		ed in the report may be	***			
İ	erroneous, mislea	ling or otherwise unreliable; or				
j	(2) the provi	der obtains information				
		ident form that was previously				
1	unavallable.	Table was previously				
		I B providers shall submit,	-			
ĺ	upon request by th	e LME, other information				
	obtained regarding	the incident, including:				
	(1) hospital	ecords including confidential			ļ	
	information;	modulig contidental				
		other authorities; and				
		ler's response to the incident.				
((Q) Category A and	B providers shall cond a conv				
	of all level III incide	nt reports to the Division of	-			
1	wental nealth, Devi	9lopmental Disabilities and			***	
3	Substance Abuse S	ervices within 72 hours of			***	
ן ג	pecoming aware of	the incident. Category A			r	
	voviders snall send	d copy of all level iii			W-Basawasa	
11	ncidents involving á	client death to the Division of				
r	realth Service Regi	Ilation within 72 hours of				
i D	ecoming aware of	the incident. In cases of			***************************************	
C	ment death within sk	even days of use of sectucion				
ļ O	r restraint, the prov	ider shall report the death			*////	
114	mileolately, as reqt	lifed by 10A NCAC 26C			WWW.	
1.6	NOTE AND A NOVE	C 27Ē .0104(e\/18\			***************************************	
(6	Category A and I	B providers shall send a				
re	≉ροπ quarterly to th	e LME responsible for the				
C	atcoment area whei	6 Sérvices are provided				
13	ne report shall be s	Upmitted on a form provided			7	
(1)	y the Secretary via	electronic means and shall				
_ in	ciude summary infe	ormation as follows:				
(7) medication	errors that do not meet the				
de	finition of a level II	or level III incident;				
(2		nterventions that do not meet				
the to	e definition of a leve	Il or level III incident:				
(3)) searches of	a client or his living area;			1	
		~ ·	4		1	1
on of Health \$	Service Regulation					
E FORM			6698			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SU COMPLET R (X4) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SU COMPLET R (X4) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SU COMPLET R (A) DEFICIENCY (A) DEFICIENCY (A) DEFICIENCY (B) PROVIDER OR SUPPLIER (C) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (C) DEFICIENCY (C) MULTIPLE CONSTRUCTION	ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WATLINGTON'S FAMILY CARE HOMES #3 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING OR 6/30 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406	(X5) COMPLETE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETS
WATLINGTON'S FAMILY CARE HOMES #3 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
Continued From page 2 (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that cocurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record review, the facility falled to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Review on 6/28/2 of the Level I incident report revealed: - "Name of Resident: [FC #6]" - "Data/time of accident/incident: 11/5/20 3:41 pm" - "Person filing Report: [Former Staff (FS) #4]" - "As I returned to the facility at 3:39 pm staff observed resident (FC #6) with her head leaning	1/3-/30sl
back as she was sitting in her wheelchair. Staff approached resident and observed her sleeping. Staff began to pick up resident out of her wheelchair and put her in bed. Staff observed white mucus coming out of her mouth and nose. Staff wiped her face with a cold compress and	

Division	of Health Service I	Requiation			PRINTED: 07/02/20/ FORM APPROVI
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			FORW APPROVI
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY
			A. BUILDING:	***************************************	COMPLETED
		35 (1) 0 34443-			
		MHL0411110	B. WING	**************************************	R 06/30/2021
MAME OF I	PROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, ST	ATE ZIP CODE	V0/30/2021
WATLING	TON'S FAMILY CAR		SHERROD-WATLIN		
		GRE GRE	ENSBORO, NC 274	OR CIRCLE	
(X4) ID	SUMMAR	Y STATEMENT OF DESIGIENAIS			***************************************
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(X5)
		ON LOOK IDENTIFY TING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	BE COMPLETE IATE DATE
Vaca	A			DEFICIENCY)	
V 367	Continued From p	age 3	V 367		
-	realized the reside	ent had "cold" body temp.	1 50,	1. Measure to correc	+ the
	(temperature) Sta	off proceeded to take her vitals		deficient area of	marke a
}	With no response	At 2:52 Laste her vitals	***************************************	l Y	
	#1]. [Licensee #1]	At 3:52 pm I notified [Licensee arrived at 3:59. Another staff	- Landerson	Administrator wil	l report
	(staff #2) tried to the	ake vital again 1916##07 ====		werel I in dont	i 100th
i	to listen for a hear	beat and pulse but still no	ļ	increase in the same of the sa	
ĺ	response. License	equate trip halles II# 95		his using TRIS WIT	her
	4:12 pm. [FC #6] v	vas taken to [local hospital]."		to see he cas	naima
1				by using IRIS wit	·····9
	Review on 6/30/21	of FC #6's medical record			
	revealed:			TO On opinion diffic	cultus
	- "Arrival Date/Time	e: 11/05/2020 1705 (5:05 pm)"		14 superior	, ,
1	 cuiei combiaiut- 	Cardiac arrest (HCC)		that prevents comp	region
	(Hierarchical Cond	ition Cateoories)"		- C - comet adminis	trator
	- "5/28/16 ESRD (e	nd stage renal disease) on		TOTE HE	la line
] '	alaiysis"	·		If experience difficulty of report, administration will call IRIS He	12 -104
•	- "37 y.o. (year old)	female with a complex			CONTRACT
1.5	neural history incl	uding dialysis for and stope		nature of problem this case repeated timing out and st	
'	ciiai uisease, cogn	IIIVė delay, known plaabat		nature of problem	, 10
	souse, currently res	liding at a facility processing		His case repeated	si l
, , <u>,</u> ,	uudy ziter peing 10	UNG Unresponence with last		INIB COURT	
, r	Jown normai at 14	30. She had a total of 10 to		timing out and si	mang
) ,	a minutes of ChK	(Cardiopulmonan)	1	down at 11:50 pm	المهم
	cesuscitation), 5 ro	inds of epinephrine given. No			
1 3	nocks were given t	Prior to arrival. She arrives	· ·	losing information e	ntered
L	uises intact, King a	irway in place that was		du to trying to list	t over
13	shaced bet the apt	ve procedure note with a 7.5		acce to	
] 2	uneu lube. Labs ar	d imaging ordered to		losing information educate to trying to list and reinformation on each.	quired
2	valuate for intracra	nial hemorrhage, sepsis,		information on each.	
9	for intubation of	ity. Levophed initiated soon		As a second different and	
re	re: intopation que l	o maps of 50-60. Patient			
/r	anid seguence let	gow Coma Scale) 3, RSI]		
90	abid sedneline illin sqativa pac pace ::	pation) was not given. No			
~	r	sed at this point. Intensivist			
at	phormality at this tir	of show any acute			
10	lectrocardioasaes	HO, UIB EKG	1		
(in	iterval seen in an E	howed prolonged QT			
_ "	Patient precents for	r unwitnessed cardiac	1		!
an	est. Last known no	rmal was 1430. Patient was	Single Control of the		
on of Health S	Service Regulation	mar was 1450. Patient was	1		
E FORM	,				
			LS96	311	Assimumitan alaun a saa

Division	of Health Service R	legulation			PRINTED: 07/ FORM APA	/Q2/20 PROV
STATEMEN AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		
		IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVE	
		ľ	i		İ	
		MHL0411110	B, WING		R	
NAME OF I	PROVIDER OR SUPPLIER	STREET	NDDRESS, CITY, S		06/30/20	21
WATLING	TON'S FAMILY CARE	1401 SU				
	TOR O I MUNICI CARE	HOMES #3 GREENS	SBORO, NC 27	INGTON CIRCLE		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DESIGNATION	ID			-
TAG	REGULATORY	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	nge i	(XB)
		or day (Silvery 1000)	TAG	CROSS-REFERENCED TO THE APPROI		MPLETE DATE
V 367	Continued From P	ana /		DEFICIENCY)		
	1	_	V 367			
	Tound by staff at he	er group home slumped over in	17444444A	2. Measures to prev		
	rier wireelchair. Kh	VIDM was asystole A 55 /action	Addition to the state of the st	problem from rea	occuring	
	FMS (omersone)	A (pulseless electrical activity).		•	7	
	(Cardionulmonand	nedical services) started CPR Resuscitation) and gave 3		· Contact IRIS	Help	
	rounds of epinenhr	ine before return of circulation.		Line for assistou		
	Repeat rhythm was	A. fib with RVR (rapid	****	Line for assisted	1100	
	ventricular respons	e), rate 1 20-1 50. Pulses	***************************************	immediately.		
1	were lost again, and	d rhythm showed torsades		immediately. . If information	n to	
	ratient was given 2	more rounds of eninanhrina		la la mal 15 less	athu.	
	wıın magneşium, Şi	he had return of circulation		be entered is ter	212	
1	Our emergency den	artment. She arrives GCS		SUBMIT U P' -		
1	(Glasgow Coma Sc	ale) 3, pulses intact, King	1	entry to create	ac ,	
	anway in place.					
-	- "Past Medical Hist	ory: Alcohol abuse choosin		control interes	and fill	
	uniculiar piholat dist	order (HCC), Chronic kidney		in data as collec	ted	
	Gisease, Dialysis -iyi	(Monday), W (Wednesday),			1	
i i	impairment. Denres	changes, Cognitive sion, Diabetes mellitus		3. Who will monitors	tration	
1	without complication	(HCC), Elevated lipids,		5, 1010 0011		
1	Hyperparathyroidism	(HCC), Hypertension,		to prevent reoccur	ance.	
	mellectual disability,	Staph aureus infection AA/	***************************************	+ Administrator, N	1 m.	
1 (arteriovenous) fistul	a and UTI (lower urinary tract	-	Wathington		
, "	machon).		<u> </u>	4		
-	"Patient Active Prot	plem List/Date Noted:		4. How often will m	onstoring	
1	Cardiac arrest (HC)	0) 11/05/2020		take place.	7	
	Critical lower limb is	disease (HCC) 10/21/2020		pare place.		
-	Perinheral arterial A	schemia 10/21/2020 isease (HCC) 09/30/2020		· Immediately		
	Pyogenic ulcer of th	ot (HCC) 09/08/2020		incident occu	rs.	
	Cellulitis and abscess	ss of toe 09/08/2020		Administrator u	, 11	
-	Sinus tachycardla 0	7/27/2020				
-	Postoperative anern	ia 07/23/2020		report any a Level Is wit	P .	
[- (Closed fracture of n	ght distal tibia 07/22/2020			hin	
" '	weakness generaliz	ed 06/28/2020		ya hours,		
**	Influenza A 01/27/20	220			1	I
-	Hypotension 01/27/2	(UXU				ı
12	Complication from re 2/12/2019	ruar dialysis device	ļ			I
	Service Regulation				1	
FORM		50	990 169	· · · · · · · · · · · · · · · · · · ·		

Division	of Health Service R	equiation			PRINTED: 0 FORM A	
STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			, with M	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUR	/EY
	Rubertude		A. SUILDING:		COMPLETE	D
	viso-Andri	300000000000000000000000000000000000000				
		MHL0411110	B. WING		R	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	Labora Meriana	<u> 06/30/2</u>	021
WATING	TANIO CARRIE V ALA					
/* 1000 1000	TON'S FAMILY CARE	HOMES #3 GREENS	ERROD-WATLIN BORO, NC 274	IGTON CIRCLE		
(X4) ID	SUMMARY	STATEMENT OF DESIGNATES	BURU, NC 2/4	06		
PREFIX TAG) (EACH DEFICIE	NOY MUST BE DECEDED BY FIRE	iD D	PROVIDER'S PLAN OF CORRECTION	V	(X5)
ING	REGULATORY	OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE c	OMPLETE
<u>-</u>				DEFICIENCY)	MATE	DATE
V 367	Continued From pa	age 5	V 367			
	1		V 367			
1	07/24/2018	of both lower extremities			1	
		The said the said and said and said and said and said and said and said and said and said and said and said and	***			
	- Hyperkalemia 07/	isability 10/17/2017			j	
1	- Adjustment disor	3 1/2U1/				
	emotions and cond	ler with mixed disturbance of			}	
	- Diabetes (HCC) 0	UGI R/GD/ONAA	***		1	
	- Essential hyperter	∪/£0/2U 10 15ion ΩE/20/304¢			ļ	
- 1	- ESRD on dialysis	(HCC) 05/20/20 15				
	- Pain of left arm 05	(//00/03/20/20/0 //27/2016"				
	- "Discharge date/fu	me: 11/07/2020 21:07*				
	- "Discharge Dispos	iltion: Expired"]		1	
	- "Discharge destina	ation: Morgue - [local hospital]"				
	3					
] :	Review on 6/28/21 of	of the Incident Response			**************************************	
	Improvement Syster	m (IRIS) revealed:				
į .	- There was not a re	port submitted to IRIS				
1	regarding FC #6's †	1/5/20 hospitalization nor her			· ·	
(death on 11/7/20.				BANAMAN	ſ
1.	***************************************		***************************************			ľ
	nterview on 6/29/2	with client #4 revealed:			***************************************	ĺ
"	On 17/5/20, staff #2	had come to the group	l		***	- 1
r	nome to relieve FS	4 for a short period of time.			W. Carrier	- I
-	Starr #2 was down	the hall in the staff office and	-		-	
3	was in her begro	om when FC #6 called out "I	***************************************		***************************************	- 1
, L	en i presine ma." Ho	#6 called her "ma"			########	
h	ome.	oldest client at the group			-	- 1
	1.77	**************************************	***************************************		***	1
b	eside her bedroom	5's bedroom which was	***************************************		***	
		hold up her head. She held				
F	C #6's bead up for	minute or two. FC #6			With the second	- 1
aı	Dogared to be broat	ning heavy but seemed to be			***	
as	sleep. She laft FC #	5's bedroom because "she	***		1	
\$6	emed to be asleep.	"				- 1
] - [Right after she left F	C #6's bedroom, FS #4 had				1
re	turned to the aroun	home and went into FC #6's	1			1
be	edroom. This was wi	nen FS #4 noticed FC #6's				ı
wa	as unresponsive.	S # 7 HOROGU FO #0				I
_ - F	S #4 tried to wake	up FC #6 and take FC #6's]		1	
on of Health S	Service Regulation	TO WILL EACH TO HOS			1	ı
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AND PLAN	OF CORRECTION	(X1) PROMOCRASUFFLIENCLIA	(X2) MULTIPLE (CONSTRUCTION	
		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED
	rubeshiane		>4.800103;	Le portivité:	
		MHL0411110	D 1819		R
****		11112411116	B. WING		06/30/2021
NAME OF F	ROVIDER OR SUPPLIER	STREE	TADDRESS, CITY, STATE	= 710 CADE	1 00/00/2021
WATLING	TON'S FAMILY CAR		SHERROD-WATLING		
		GREE #3	NSBORO, NC 27406	TON CIRCLE	
(X4) ID	SUMMAR	Y STATEMENT OF DECICIENDICS	7 7 2/400		
PREFIX TAG	(EACH DEFICE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	HADE
V 367	Continued From p	age 6	11005	50.100.17	
	}		V 367		
	blood pressure.		S. WARRING		
	- FC #4 called the	Licensee #1 who told FC #4 to	A CONTRACTOR OF THE CONTRACTOR		
	call 911.	4			
	- The Licensee #1	had come into the group home			
;	EMC and the	ing on her (FC #6's) chest."			
	- EMS and the pol	ce arrived.			
	Interview consu	ريسان فيو السا			
İ	- On 11/6/20 + 1	21 with staff #2 revealed:	***************************************		
	Davebook and star	ad come to pick up her			
i	with the clients whi	ed for a short period of time le FS #4 left to cash her			
ĺ	paycheck Shoeta	vod et the annual a			
-	about 20 minutes.	yed at the group home for			
		FC #6 in her bedroom with			
	her door open. FC	#6 was in her wheelchair			
	talking to client #4	FC #6 "seemed to be fine."			
	- She overheard Fo	#6 tell client #4 she was			
1	lired. Then she hea	rd client #4 say to FC #6	***************************************		
	what do you want	me to do?"			
-	- She never heard F	C #6 state she could not			* A Production of the Control of the
1	preathe. She never	saw client #4 hold FC #6's			Meeting-
l h	nead. She only saw	client #4 stand in front of FC			
₹	76 and FC #6 was it	n her wheelchair.			
-	Soon FS #4 return	ed and she left.			**************************************
	When she was abo	out 10 minutes away from the			MM
9	roup nome, FS #4	called her and said			***
S	omething was wron	g With FC #6. FS #4 told her			
Q	on the phone that sh	e took FC #6's pulse but the	- Section 1		
i n	nachine was not wo	rking,	all and the second		**************************************
-	one drove back to	the group home and when			-
5	ne arrived at the gr	DUP home, she took FC #6'e			9,,
P	uise. FU #6 had no	pulse. FS #4 was on the			***
P	none with the Licen	see #1 who was already in			
	voic in the group ho	me. The Licensee #1 arrived			
	ery quickly.				
h	***** ********************************	arted CPR on FC #6. She			
) 170 _ 1	FS #4 Was von	the Licensee called 911.			
do	Own as the netice -	et and she calmed FS #4			
1	own as the police a	iu Eivio amved.			
on of Health	Service Regulation				
E FORM	~~· 10-0 1/DANIGHOU				
			6099 LS961	1	Mary and the same of

Division	of Health Service I	Regulation				D: 07/02/202 M APPROVE
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
	The second secon	IDENTIFICATION NUMBER;	A. BUILDING:		(X3) DATE	SURVEY LETED
					1	
		MHL0411110	B. WING			R
NAME OF I	PROVIDER OR SUPPLIEF	STREE	T ADDRESS, CITY, STAT		1 06/:	30/2021
WATI ING	STON'S FAMILY CAR					
************	TON STAINILY CAR	HOMES #3	SHERROD-WATLING NSBORO, NC 27400			
(X4) ID	SUMMAR	Y STATEMENT OF DESICIENCIES				
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS DEED TO THE ACTION SHOT	lines	(X5) COMPLETE
				CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
V 367	The state of the s	_	V 367			
	Interview on 6/30/	21 with FS #4 revealed:	***************************************			
	- On 11/5/20 she	had asked Licensee #1 if etaff				
i	#∠ could come in	for a short period of time and				
	Provide care to the	clients while she went to the				
	Dank. Ine License	9 #1 granted her permission to				
	leave while staff #	2 provided care to the clients			}	
	one was gone for	about 30 minutes-45 minutes			-	
	- when she left to	go to the baлk, FC #6 was			•	
	sitting at the kitche	n table having lunch.				
	- when she return	ed, she saw some of the clients				
	on the back porch	and one client inside. She				
	Sho united to #6	was not at the kitchen table.				
	One warken to the	staff office and told staff #2 she				
	#6's bedroom.	left. Then she walked to FC			***************************************	
		0.46				
	wheelchair and che	C #6 was asleep in her tried to put FC #6 in bed.			***	
	- When she nut FA	#6 in the bed, she noticed FC				
	#6's skin felt cold a	nd moist. When she laid FC				
	#6 down white stuff	had come out of FC #6's				
	mouth and nose. S	ne kept saying [FC #6's name]			WHENANA	
1 :	and more white stu	f had come out of FC #6's			VARIBURA 1411.	
1	mouth and nose.	. Tree come add of LC #08			waterway.	
		plood pressure every morning			**************************************	
a	and was used to tal	ing FC #6's blood pressure.				
	She attempted to ta	ke FC #6's blood pressure but				
t	he machine kept sh	owing an error. She put the			***************************************	
S	stethoscope to FC #	6's heart and did not hear			***************************************	
6	anything.					
-	She called the Lice	nsee #1 who was already in			Yr dwarannau.	I
1 10	onte to the atonb bi	PMe and about 3 minutes			Armano-Hann]
Į a	lway. She explained	to the Licensee what had			**************************************	1
10	ccurred. She also	called staff #2 who said to			***	ŀ
n	er, that she (staff#	2) had just left and what			Western - Was	
į c	ould have happene	d to FC #6.			-	1
-	The Licensee calle	911 and used the			1	
51	tethoscope to listen	for FC #6's heart heat but]			
j n	e ald not hear anyth	ing. The Licensee started				
	rk.					1
	EMS and the police	arrived about 5-6 minutes			1	
ion of Health	Service Regulation			 		
E FORM			6876 LS961	15	44	
		,		•	If continuous.	5 540

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (ONSTRUCTION		
		IDENTIFICATION NUMBER:	A. BUILDING:	201011001104	(X3) DATE SURVEY	
	}		THE STREET,		COMPLETED	
	Principalista	MHL0411110	B MANAGE		R	
NAME OF F	No. 11 (1997)		B. WING		06/30/202	24
MUNIC OF F	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STATE	, ZIP CODE		
WATLING	TON'S FAMILY CARE		RROD-WATLING			
		GREENSI	30RO, NC 27406			
(X4) ID PREFIX	SUMMARY	Y STATEMENT OF DEFICIENCIES	[10 T			
TAG	REGULATORY	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		(X\$)
•		ON ESCIDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	SE CON	MPLETE
				DEFICIENCY)	/ C	ATE
V 367	Continued From pa	age 8	V 367			
	later. FC #6 was to	iken to the hospital where she				
	died a couple days	later				
	- Her CPR training	was current at the time of the]	
	11/5/20 incident.	mea content at the time of the				
]		a report to IRIS about the				
	11/5/20 incident but	t did write up a level I incident			<u> </u>	
1	report.	- The mile up a term tillicidellt				
	·					
	Interviews on 6/29/2	21 and 6/30/21 with the				
	Licensee #1 reveale	ed:				
	- FC #6 had multiple	e surgeries and health issues				
i	including type 1 dia	betes. FC #3 had End Stage				
	Renal Disease and	had been receiving dialysis 3				
i	umes a week					
	- In October 2020, F	FC #6 had her blood vessels				
	granted from her upp	per legs and the blood vaccale	***			
j '	were biaced in her k	ower legs/feet due to poor	W			
'	circulation.				****	
}.	- On 11/4/20, he had	taken FC #6 to her dialysis				
] *	appointment and to:	a medical appointment The	7		Manual Comment	
1 (accior did not havela	any concerns and sent her	***************************************		**************************************	
r	rome. He took her to	o dialysis 3 times a week	·		-	
	' Un 11/5/20, he had	been at the group home and				
,	ioticea FC #6 did no	teata lot of lunch As ha laff	***		***************************************	- 1
l ti	ne group home that	afternoon FC #6 had seked			***************************************	J
l L	ilm to bring back hei	r favorite food which was	***************************************			- 1
	igs reet.	j	**************************************		WWW.	
	As ne drove back to	the group home on 11/5/20,	*		Weellers	1
14	e received a phone	Call from FS #4 FS #4				
1.0	idicated she could h	ot get a pulse reading on FC	-			- 1
17	O.				**** ********************************	
	Opon arrival at the g	group home he found FC #6			***************************************	- 1
111	mar bearoom, FCB	F6 was on her bed. FS #4			***	
}	au ine blood pressig	re cuff on FC #6 and was				1
l Ci	necking for a pulse.					1
} ; +=	ne called 911. The	911 operator instructed him				
, to	nove FC #5 an	d to start CPR immediately.				
,	e continued CPR un	til the EMS arrived, EMS	1			
į Wi	as able to get FC #6	's heart beating prior to				
On of Beattle	ansporting her to the	nospital.				
on Health : E FORM	Service Regulation		"			

MHL0411110 B. WING	
MHL0411110 MTMC GREENSBORO, NC 27406 MHL041 FREFIX (EACH DEFICIENCY PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 367 Continued From page 9 V 367 Continued From page 9 V 367 On 11/6/20 he attempted to put a report in IRIS twice regarding FC #6's hospitalization. - He called the IRIS staff on 11/6/20 and left a message but they never returned his call. - He never reported FC #6's death to IRIS. - "I don't know if it (the IRIS report) ever showed as received. I was never able to make a copy (of	ATE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY. STATE, ZIP CODE 1401 SHERROD-WATLINGTON CIRCLE GREENSBORO, NC 27406 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL, TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL, TAG (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 9 V 367 Continued From page 9 V 367 Continued From page 9 V 367 V 367 V 367 Continued From page 9 V 367 I don't know if it (the IRIS report) ever showed as received. I was never able to make a conv (of	MPLETED
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WATLINGTON'S FAMILY CARE HOMES #3 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH OF CORRECTION SHOULD BE (EACH DEFICIENCY) OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 9 - On 11/6/20 he attempted to put a report in IRIS twice regarding FC #6's hospitalization He called the IRIS staff on 11/6/20 and left a message but they never returned his call "I don't know if it (the IRIS report) ever showed as received. I was never able to make a copy (of	R 06/30/2021
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as received. I was never able to make a copy (of	
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the report he typed)."	[{
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FORM	
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ROY COOPER . Governor MANDY COHEN, MD, MPH · Secretary MARK PAYNE • Director, Division of Health Service Regulation

July 7, 2021

Romulus T. Watlington, Licensee Bonnie Watlington & Romulus Thurman Watlington 1401 Sherrod-Watlington Circle Greensboro, North Carolina 27406

Re: Annual and Follow Up Survey completed June 30, 2021

Wattington's Family Care Homes #3, 1401 Sherrod-Wattington Circle, Greensboro, NC. 27406

E-mail Address: <u>bwatli222@gmail.com</u>

Dear Mr. Watlington:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of

Type of Deficiencies Found

All other tags cited are standard level deficiencies.

Time Frames for Compliance

Standard level deficiency must be corrected within 60 days from the exit of the survey, which is August 29, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to prevent the problem from occurring again.
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. Please do not include confidential information in your plan of correction and please remember never to send confidential Information (protected health information) via email.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Urnstead Drive, Williams Building, Raleigh, NC 27603 MAILING ADDRESS: 2718 Mall Service Center, Raieigh, NC 27699-2718 www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

July 7, 2021 Romulus T. Watlington

Send the <u>original</u> completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Barbara Perdue at (336) 861-6283.

Sincerely,

Angela C. Medlin, MSW

Angely Modelin

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Cc:

DHSR Letters@sandhillscenter.org Pam Pridgen, Administrative Assistant