PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 000	INITIAL COMMENTS An Annual and Follow-Up Survey was completed on 6/30/21. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C: Supervised Living for Developmentally Disabled Adults	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required	V 367		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bonnie Watlington

TITLE: Administrator/OP

(X6) DATE: 8/26/21

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 1 report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	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 occurred; 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 failed 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 6/28/21 of the Level I incident report revealed: - "Name of Resident: [FC #6]" - "Date/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 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	V 367	Plan of Correction Time fram for compliance: Administrator completed IRIS report on 7/2/21, File # [redacted] Administrator reported that client [redacted] was transported by ambulance to hospital on 11/5/20 and she passed in hospital on 11/7/20.	7/7/2021

PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 3 realized the resident had "cold" body temp. (temperature). Staff proceeded to take her vitals with no response. At 3:52 pm I notified [Licensee #1]. [Licensee #1] arrived at 3:59. Another staff (staff #2) tried to take vital again. [Staff #2] began to listen for a heartbeat and pulse but still no response. [Licensee #1] called 911 at around 4:12 pm. [FC #6] was taken to [local hospital]." Review on 6/30/21 of FC #6's medical record revealed: - "Arrival Date/Time: 11/05/2020 1705 (5:05 pm)" - "Chief complaint- cardiac arrest (HCC) (Hierarchical Condition Categories)" - "5/28/16 ESRD (end stage renal disease) on dialysis ..." - "37 y.o. (year old) female with a complex medical history including dialysis for end-stage renal disease, cognitive delay, known alcohol abuse, currently residing at a facility presenting today after being found unresponsive with last known normal at 1430. She had a total of 10 to 15 minutes of CPR (Cardiopulmonary Resuscitation), 5 rounds of epinephrine given. No shocks were given prior to arrival. She arrives pulses intact, King airway in place that was replaced per the above procedure note with a 7.5 cuffed tube. Labs and imaging ordered to evaluate for intracranial hemorrhage, sepsis, electrolyte abnormality. Levophed initiated soon after intubation due to maps of 50-60. Patient remained GCS (Glasgow Coma Scale) 3, RSI (rapid sequence intubation) was not given. No sedation has been used at this point. Intensivist consulted. Labs do not show any acute abnormality at this time, the EKG (electrocardiogram) showed prolonged QT (interval seen in an EKG)." - "Patient presents for unwitnessed cardiac arrest. Last known normal was 1430. Patient was	V 367	1. Measure to correct the deficient area of practice: Administrator will report Level II incidents to LME by using IRIS within 72 hours of becoming aware of incident. If experience difficulty that prevents completion of report, administrator will call IRIS Help Line for assistance and report nature of problem, in this case repeated timing out and shutting down at 11:50 pm and losing information entered due to trying to list over 25 medication and required information on each.	

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 4 found by staff at her group home slumped over in her wheelchair. Rhythm was asystole, A. fib (atrial fibrillation) with PEA (pulseless electrical activity). EMS (emergency medical services) started CPR (Cardiopulmonary Resuscitation) and gave 3 rounds of epinephrine before return of circulation. Repeat rhythm was A. fib with RVR (rapid ventricular response), rate 1 20-1 50. Pulses were lost again, and rhythm showed torsades. Patient was given 2 more rounds of epinephrine with magnesium. She had return of circulation and rise after 7 minutes of circulation return to our emergency department. She arrives GCS (Glasgow Coma Scale) 3, pulses intact, King airway in place." - "Past Medical History: Alcohol abuse chronic, Anemia. Bipolar disorder (HCC), Chronic kidney disease, Dialysis -M (Monday), W (Wednesday), F (Friday), Cognitive changes, Cognitive impairment, Depression, Diabetes mellitus without complication (HCC), Elevated lipids, Hyperparathyroidism (HCC), Hypertension, Intellectual disability, Staph aureus infection, A/V (arteriovenous) fistula and UTI (lower urinary tract infection)" - "Patient Active Problem List/Date Noted: - Cardiac arrest (HCC) 11/05/2020 - Peripheral vascular disease (HCC) 10/21/2020 - Critical lower limb ischemia 10/21/2020 - Peripheral arterial disease (HCC) 09/30/2020 - Pyogenic ulcer of foot (HCC) 09/08/2020 - Cellulitis and abscess of toe 09/08/2020 - Sinus tachycardia 07/27/2020 - Postoperative anemia 07/23/2020 - Closed fracture of right distal tibia 07/22/2020 - Weakness generalized 06/28/2020 - Influenza A 01/27/2020 - Hypotension 01/27/2020 - Complication from renal dialysis device 12/12/2019	V 367	2. Measures to prevent problem from reoccuring: • Contact IRIS Help Line for assistance immediately. • If information to be entered is lengthy, submit a preliminary entry to create a control number and come back later and fill in data as collected. 3. Who will monitor situation to prevent reoccurance. • Administrator, Mr. Watlington 4. How often will monitoring take place. • Immediately when incident occurs. Administrator will report any and all Level II's within 72 hours.	

PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 5 - Multiple fractures of both lower extremities 07/24/2018 - Mild intellectual disability 10/17/2017 - Hyperkalemia 07/31/2017 - Adjustment disorder with mixed disturbance of emotions and conduct - Diabetes (HCC) 05/28/2016 - Essential hypertension 05/28/2016 - ESRD on dialysis (HCC) 05/28/2016 - Pain of left arm 05/27/2016" - "Discharge date/time: 11/07/2020 21:07" - "Discharge Disposition: Expired" - "Discharge destination: Morgue - [local hospital]" Review on 6/28/21 of the Incident Response Improvement System (IRIS) revealed: - There was not a report submitted to IRIS regarding FC #6's 11/5/20 hospitalization nor her death on 11/7/20. Interview on 6/29/21 with client #4 revealed: - On 11/5/20, staff #2 had come to the group home to relieve FS #4 for a short period of time. - Staff #2 was down the hall in the staff office and she was in her bedroom when FC #6 called out "I can't breathe ma." FC #6 called her "ma" because she was the oldest client at the group home. - She went into FC #6's bedroom which was beside her bedroom. - FC #6 asked her to hold up her head. She held FC #6's head up for a minute or two. FC #6 appeared to be breathing heavy but seemed to be asleep. She left FC #6's bedroom because "she seemed to be asleep." - Right after she left FC #6's bedroom, FS #4 had returned to the group home and went into FC #6's bedroom. This was when FS #4 noticed FC #6 was unresponsive. - FS #4 tried to wake up FC #6 and take FC #6's	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 6 blood pressure. - FC #4 called the Licensee #1 who told FC #4 to call 911. - The Licensee #1 had come into the group home and "started pumping on her (FC #6's) chest." - EMS and the police arrived. Interview on 6/29/21 with staff #2 revealed: - On 11/5/20, she had come to pick up her paycheck and stayed for a short period of time with the clients while FS #4 left to cash her paycheck. She stayed at the group home for about 20 minutes. - She had observed 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 FC #6 tell client #4 she was tired. Then she heard client #4 say to FC #6 "what do you want me to do?" - She never heard FC #6 state she could not breathe. She never saw client #4 hold FC #6's head. She only saw client #4 stand in front of FC #6 and FC #6 was in her wheelchair. - Soon FS #4 returned and she left. - When she was about 10 minutes away from the group home, FS #4 called her and said something was wrong with FC #6. FS #4 told her on the phone that she took FC #6's pulse but the machine was not working. - She drove back to the group home and when she arrived at the group home, she took FC #6's pulse. FC #6 had no pulse. FS #4 was on the phone with the Licensee #1 who was already in route to the group home. The Licensee #1 arrived very quickly. - The Licensee #1 started CPR on FC #6. She helped do CPR while the Licensee called 911. - FS #4 was very upset and she calmed FS #4 down as the police and EMS arrived.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 7 Interview on 6/30/21 with FS #4 revealed: - On 11/5/20 she had asked Licensee #1 if staff #2 could come in for a short period of time and provide care to the clients while she went to the bank. The Licensee #1 granted her permission to leave while staff #2 provided care to the clients. She was gone for about 30 minutes-45 minutes. - When she left to go to the bank, FC #6 was sitting at the kitchen table having lunch. - When she returned, she saw some of the clients on the back porch and one client inside. She noticed that FC #6 was not at the kitchen table. She walked to the staff office and told staff #2 she was back. Staff #2 left. Then she walked to FC #6's bedroom. - She noticed that FC #6 was asleep in her wheelchair and she tried to put FC #6 in bed. - When she put FC #6 in the bed, she noticed FC #6's skin felt cold and moist. When she laid FC #6 down white stuff had come out of FC #6's mouth and nose. She kept saying [FC #6's name] and more white stuff had come out of FC #6's mouth and nose. - She took FC #6's blood pressure every morning and was used to taking FC #6's blood pressure. She attempted to take FC #6's blood pressure but the machine kept showing an error. She put the stethoscope to FC #6's heart and did not hear anything. - She called the Licensee #1 who was already in route to the group home and about 3 minutes away. She explained to the Licensee what had occurred. She also called staff #2 who said to her, that she (staff #2) had just left and what could have happened to FC #6. - The Licensee called 911 and used the stethoscope to listen for FC #6's heart beat but he did not hear anything. The Licensee started CPR. - EMS and the police arrived about 5-6 minutes	V 367		

PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 8 later. FC #6 was taken to the hospital where she died a couple days later. - Her CPR training was current at the time of the 11/5/20 incident. - She did not make a report to IRIS about the 11/5/20 incident but did write up a level I incident report. Interviews on 6/29/21 and 6/30/21 with the Licensee #1 revealed: - FC #6 had multiple surgeries and health issues including type 1 diabetes. FC #3 had End Stage Renal Disease and had been receiving dialysis 3 times a week - In October 2020, FC #6 had her blood vessels grafted from her upper legs and the blood vessels were placed in her lower legs/feet due to poor circulation. - On 11/4/20, he had taken FC #6 to her dialysis appointment and to a medical appointment. The doctor did not have any concerns and sent her home. He took her to dialysis 3 times a week. - On 11/5/20, he had been at the group home and noticed FC #6 did not eat a lot of lunch. As he left the group home that afternoon FC #6 had asked him to bring back her favorite food which was pigs' feet. - As he drove back to the group home on 11/5/20, he received a phone call from FS #4. FS #4 indicated she could not get a pulse reading on FC #6. - Upon arrival at the group home he found FC #6 in her bedroom. FC #6 was on her bed. FS #4 had the blood pressure cuff on FC #6 and was checking for a pulse. - He called 911. The 911 operator instructed him to not move FC #6 and to start CPR immediately. He continued CPR until the EMS arrived. EMS was able to get FC #6's heart beating prior to transporting her to the hospital.	V 367		

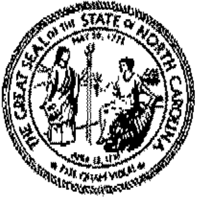
PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
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. - 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 the report he typed)."	V 367		



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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: bwatll222@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.

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.***

Send the original 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
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant

Division of Health Service Regulation

PRINTED: 07/02/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

NAME OF PROVIDER OR SUPPLIER: WATLINGTON'S FAMILY CARE HOMES #3

STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 SHERROD-WATLINGTON CIRCLE, GREENSBORO, NC 27406

(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
V 000	INITIAL COMMENTS An Annual and Follow-Up Survey was completed on 6/30/21. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C; Supervised Living for Developmentally Disabled Adults	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required	V 367		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bonnie Watlington

TITLE: Administrator/OP

(X6) DATE: 8/26/21

Division of Health Service Regulation

PRINTED: 07/02/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

NAME OF PROVIDER OR SUPPLIER: WATLINGTON'S FAMILY CARE HOMES #3

STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 SHERROD-WATLINGTON CIRCLE, GREENSBORO, NC 27406

(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
V 367	Continued From page 1 report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area;	V 367		

PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	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 occurred; 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 failed 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 6/28/21 of the Level I incident report revealed: - "Name of Resident: [FC #6]" - "Date/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 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	V 367	Plan of Correction Time fram for compliance: Administrator completed IRIS report on 7/2/21, File [redacted] Administrator reported that client [redacted] was transported by ambulance to hospital on 11/5/20 and she passed in hospital on 11/7/20.	7/2/2021

Division of Health Service Regulation

PRINTED: 07/02/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

NAME OF PROVIDER OR SUPPLIER: WATLINGTON'S FAMILY CARE HOMES #3

STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 SHERROD-WATLINGTON CIRCLE, GREENSBORO, NC 27406

(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
V 367	Continued From page 3 realized the resident had "cold" body temp. (temperature). Staff proceeded to take her vitals with no response. At 3:52 pm I notified [Licensee #1]. [Licensee #1] arrived at 3:59. Another staff (staff #2) tried to take vital again. [Staff #2] began to listen for a heartbeat and pulse but still no response. [Licensee #1] called 911 at around 4:12 pm. [FC #6] was taken to [local hospital]." Review on 6/30/21 of FC #6's medical record revealed: - "Arrival Date/Time: 11/05/2020 1705 (5:05 pm)" - "Chief complaint- cardiac arrest (HCC) (Hierarchical Condition Categories)" - "5/28/16 ESRD (end stage renal disease) on dialysis ..." - "37 y.o. (year old) female with a complex medical history including dialysis for end-stage renal disease, cognitive delay, known alcohol abuse, currently residing at a facility presenting today after being found unresponsive with last known normal at 1430. She had a total of 10 to 15 minutes of CPR (Cardiopulmonary Resuscitation), 5 rounds of epinephrine given. No shocks were given prior to arrival. She arrives pulses intact, King airway in place that was replaced per the above procedure note with a 7.5 cuffed tube. Labs and imaging ordered to evaluate for intracranial hemorrhage, sepsis, electrolyte abnormality. Levophed initiated soon after intubation due to maps of 50-60. Patient remained GCS (Glasgow Coma Scale) 3, RSI (rapid sequence intubation) was not given. No sedation has been used at this point. Intensivist consulted. Labs do not show any acute abnormality at this time, the EKG (electrocardiogram) showed prolonged QT (interval seen in an EKG)." - "Patient presents for unwitnessed cardiac arrest. Last known normal was 1430. Patient was	V 367	1. Measure to correct the deficient area of practice: Administrator will report level II incidents to IMF by using IRIS within 72 hours of becoming aware of incident. If experience difficulty that prevents completion of report, administrator will call IRIS Help Line for assistance and report nature of problem, in this case repeated timing out and shutting down at 11:50 pm and losing information entered due to trying to list over 25 medication and required information on each.	

Division of Health Service Regulation

PRINTED: 07/02/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 4 found by staff at her group home slumped over in her wheelchair. Rhythm was asystole, A. fib (atrial fibrillation) with PEA (pulseless electrical activity). EMS (emergency medical services) started CPR (Cardiopulmonary Resuscitation) and gave 3 rounds of epinephrine before return of circulation. Repeat rhythm was A. fib with RVR (rapid ventricular response), rate 1 20-1 50. Pulses were lost again, and rhythm showed torsades. Patient was given 2 more rounds of epinephrine with magnesium. She had return of circulation [illegible] minutes of circulation return to our emergency department. She arrives GCS (Glasgow Coma Scale) 3, pulses intact, King airway in place." - "Past Medical History: Alcohol abuse chronic Anemia, Bipolar disorder (HCC), Chronic kidney disease, Dialysis -M (Monday), W (Wednesday), F (Friday), Cognitive changes, Cognitive impairment, Depression, Diabetes mellitus without complication (HCC), Elevated lipids, Hyperparathyroidism (HCC), Hypertension, Intellectual disability, Staph aureus infection, A/V (arteriovenous) fistula and UTI (lower urinary tract infection)" - "Patient Active Problem List/Date Noted: - Cardiac arrest (HCC) 11/05/2020 - Peripheral vascular disease (HCC) 10/21/2020 - Critical lower limb ischemia 10/21/2020 - Peripheral arterial disease (HCC) 09/30/2020 - Pyogenic ulcer of foot (HCC) 09/08/2020 - Cellulitis and abscess of toe 09/08/2020 - Sinus tachycardia 07/27/2020 - Postoperative anemia 07/23/2020 - Closed fracture of right distal tibia 07/22/2020 - Weakness generalized 06/28/2020 - Influenza A 01/27/2020 - Hypotension 01/27/2020 - Complication from renal dialysis device 12/12/2019	V 367	2. Measures to prevent problem from reoccuring: • Contact IRIS Help Line for assistance immediately. • If information to be entered is lengthy, submit a pr[illegible] entry to create a control number and come back later and fill in data as collected. 3. Who will monitor situation to prevent reoccurance. • Administrator, Mr. Watlington 4. How often will monitoring take place. • Immediately when incident occurs. Administrator will report any and all Level II's within 72 hours.	

Division of Health Service Regulation

PRINTED: 07/02/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 5 - Multiple fractures of both lower extremities 07/24/2018 - Mild intellectual disability 10/17/2017 - Hyperkalemia 07/31/2017 - Adjustment disorder with mixed disturbance of emotions and conduct - Diabetes (HCC) 05/28/2016 - Essential hypertension 05/28/2016 - ESRD on dialysis (HCC) 05/28/2016 - Pain of left arm 05/27/2016" - "Discharge date/time: 11/07/2020 21:07" - "Discharge Disposition: Expired" - "Discharge destination: Morgue - [local hospital]" Review on 6/28/21 of the Incident Response Improvement System (IRIS) revealed: - There was not a report submitted to IRIS regarding FC #6's 11/5/20 hospitalization nor her death on 11/7/20. Interview on 6/29/21 with client #4 revealed: - On 11/5/20, staff #2 had come to the group home to relieve FS #4 for a short period of time. - Staff #2 was down the hall in the staff office and she was in her bedroom when FC #6 called out "I can't breathe ma." FC #6 called her "ma" because she was the oldest client at the group home. - She went into FC #6's bedroom which was beside her bedroom. - FC #6 asked her to hold up her head. She held FC #6's head up for a minute or two. FC #6 appeared to be breathing heavy but seemed to be asleep. She left FC #6's bedroom because "she seemed to be asleep." - Right after she left FC #6's bedroom, FS #4 had returned to the group home and went into FC #6's bedroom. This was when FS #4 noticed FC #6 was unresponsive. - FS #4 tried to wake up FC #6 and take FC #6's	V 367		

Division of Health Service Regulation

PRINTED: 07/02/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED R 06/30/2021

NAME OF PROVIDER OR SUPPLIER: WATLINGTON'S FAMILY CARE HOMES #3

STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 SHERROD-WATLINGTON CIRCLE, GREENSBORO, NC 27406

(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
V 367	Continued From page 6 blood pressure. - FC #4 called the Licensee #1 who told FC #4 to call 911. - The Licensee #1 had come into the group home and "started pumping on her (FC #6's) chest." - EMS and the police arrived. Interview on 6/29/21 with staff #2 revealed: - On 11/5/20, she had come to pick up her paycheck and stayed for a short period of time with the clients while FS #4 left to cash her paycheck. She stayed at the group home for about 20 minutes. - She had observed 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 FC #6 tell client #4 she was tired. Then she heard client #4 say to FC #6 "what do you want me to do?" - She never heard FC #6 state she could not breathe. She never saw client #4 hold FC #6's head. She only saw client #4 stand in front of FC #6 and FC #6 was in her wheelchair. - Soon FS #4 returned and she left. - When she was about 10 minutes away from the group home, FS #4 called her and said something was wrong with FC #6. FS #4 told her on the phone that she took FC #6's pulse but the machine was not working. - She drove back to the group home and when she arrived at the group home, she took FC #6's pulse. FC #6 had no pulse. FS #4 was on the phone with the Licensee #1 who was already in route to the group home. The Licensee #1 arrived very quickly. - The Licensee #1 started CPR on FC #6. She helped do CPR while the Licensee called 911. - FS #4 was very upset and she calmed FS #4 down as the police and EMS arrived.	V 367		

Division of Health Service Regulation

PRINTED: 07/02/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 7 Interview on 6/30/21 with FS #4 revealed: - On 11/5/20 she had asked Licensee #1 if staff #2 could come in for a short period of time and provide care to the clients while she went to the bank. The Licensee #1 granted her permission to leave while staff #2 provided care to the clients. She was gone for about 30 minutes-45 minutes. - When she left to go to the bank, FC #6 was sitting at the kitchen table having lunch. - When she returned, she saw some of the clients on the back porch and one client inside. She noticed that FC #6 was not at the kitchen table. She walked to the staff office and told staff #2 she was back. Staff #2 left. Then she walked to FC #6's bedroom. - She noticed that FC #6 was asleep in her wheelchair and she tried to put FC #6 in bed. - When she put FC #6 in the bed, she noticed FC #6's skin felt cold and moist. When she laid FC #6 down white stuff had come out of FC #6's mouth and nose. She kept saying [FC #6's name] and more white stuff had come out of FC #6's mouth and nose. - She took FC #6's blood pressure every morning and was used to taking FC #6's blood pressure. She attempted to take FC #6's blood pressure but the machine kept showing an error. She put the stethoscope to FC #6's heart and did not hear anything. - She called the Licensee #1 who was already in route to the group home and about 3 minutes away. She explained to the Licensee what had occurred. She also called staff #2 who said to her, that she (staff #2) had just left and what could have happened to FC #6. - The Licensee called 911 and used the stethoscope to listen for FC #6's heart beat but he did not hear anything. The Licensee started CPR. - EMS and the police arrived about 5-6 minutes	V 367		

PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
V 367	Continued From page 8 later. FC #6 was taken to the hospital where she died a couple days later. - Her CPR training was current at the time of the 11/5/20 incident. - She did not make a report to IRIS about the 11/5/20 incident but did write up a level I incident report. Interviews on 6/29/21 and 6/30/21 with the Licensee #1 revealed: - FC #6 had multiple surgeries and health issues including type 1 diabetes. FC #3 had End Stage Renal Disease and had been receiving dialysis 3 times a week - In October 2020, FC #6 had her blood vessels grafted from her upper legs and the blood vessels were placed in her lower legs/feet due to poor circulation. - On 11/4/20, he had taken FC #6 to her dialysis appointment and to a medical appointment. The doctor did not have any concerns and sent her home. He took her to dialysis 3 times a week. - On 11/5/20, he had been at the group home and noticed FC #6 did not eat a lot of lunch. As he left the group home that afternoon FC #6 had asked him to bring back her favorite food which was pigs' feet. - As he drove back to the group home on 11/5/20, he received a phone call from FS #4. FS #4 indicated she could not get a pulse reading on FC #6. - Upon arrival at the group home he found FC #6 in her bedroom. FC #6 was on her bed. FS #4 had the blood pressure cuff on FC #6 and was checking for a pulse. - He called 911. The 911 operator instructed him to not move FC #6 and to start CPR immediately. He continued CPR until the EMS arrived. EMS was able to get FC #6's heart beating prior to transporting her to the hospital.	V 367		

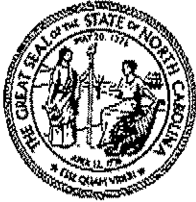
PRINTED: 07/02/2021
FORM APPROVED

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
	MHL0411110	A. BUILDING: ______ B. WING ______	R 06/30/2021

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 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
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. - 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 the report he typed)."	V 367		



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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: bwatli222@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.

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.***

Send the original 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
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant