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
	MHL051-203	A. BUILDING: _____ B. WING _____	R 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME	3310 NC 210 HWY SMITHFIELD, NC 27577

(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 & follow up survey was completed on 8/31/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire & disaster drills were repeated on each shift. The findings are: Review of the facility's fire and disaster log revealed:	V 114	Staff will be re trained on how to complete drills like fire, tornado and any other natural disaters that may arise. Administrator or designated staff will ensure that before any new hire resumes work, the new staff will demonstrate how to complete drills, types of drills and all the safety information involved. Administrator or designated staff will review new hire records quarterly to ensure compliance. DHSR - Mental Health SEP 23 2022 Lic. & Cert. Section	09\30\22 and on going.

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

Administrator — 9/21/22

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V 114	Continued From page 1 - fire and disaster drills were not completed on each shift During interview on 8/19/22 the House Supervisor reported the following staff shifts: - 1st shift - 6am - 4pm - 2nd shift - 4pm - 12am - 3rd shift - 12am - 6am During interview on 8/23/22 the Licensee reported the following staff shifts: - 2 different shifts - 7am - 7pm & 7pm - 7am During interview on 8/19/22 client #3 reported: - he would not know what to do if it was a tornado During interview on 8/19/22 client #5 reported: - disaster drills were not practiced at the facility - would get down away from windows During interview on 8/19/22 staff #1 reported: - had worked at the facility for last month - had not completed any disaster drills - no one had trained him what to do during a tornado - will google to see how to complete the tornado drill - during a tornado, would have the clients get in the bed and do not move During interview on 8/19/22 the HS reported: - she had not practiced tornado drills with staff #1 - another staff trained staff #1 this weekend, how to conduct a tornado drill - clients were to get down in the hallway During interview on 8/23/22 the Licensee	V 114		

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V 114	Continued From page 2 reported: - HS checked quarterly to see if drills were done - she and the HS ensured staff were trained on how to complete drills - she had not trained staff #1 how to conduct a tornado drill	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118		

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V 118	Continued From page 3 with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed administer medications on a written physician's order & and failed to keep MARs current for 1 of 3 audited client (3). The findings are: Review on 8/17/22 of client #3's record revealed: - admitted 8/3/22 - diagnoses of Schizophrenia, Diabetes, Alcohol abuse and Chronic Hyponatremia - a FL2 dated 8/8/22: Cogentin 1mg (milligram) (Parkinson & side effects), Ingrezza (involuntary movement), Zoloft 25mg everyday (depression), Haldol 20mg twice a day (BID) (mental disorders) & Abilify 5mg bedtime (schizophrenia); Metformin 500mg BID (diabetes), Lisinopril 10mg daily (blood pressure), Tripletail 150mg BID (seizure) & Lasix 40mg daily (fluid retention) Review on 8/17/22 of client #3's August MAR revealed: - no staff initials from 8/15/22 - 8/17/22 for the above medications - the Cogentin, Zoloft, Haldol & Abilify was not listed During interview on 8/19/22 client #3 reported: - received his medications daily by staff #1 During interview on 8/17/22 & 8/19/22 staff #1 reported:	V 118		

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V 118	Continued From page 4 - was the only staff administered medications - only signed off on the medications listed in the electronic MAR system (EMAR) - did not have a hard copy of the client #3's MAR to sign off - EMAR system had been down since 8/15/22 - road construction prevented the EMAR system from working - the House Supervisor (HS) informed him today to start to document in the EMAR & hard copy of MARs - client #3 did not miss his medications, even though, there were no documentation on the MAR During interview on 8/17/22 & 8/19/22 the HS reported: - on 8/17/22 the EMAR system down had been down since 8/15/22 due road construction, - the internet line was cut - client #3 was new to the facility and not all his medications had been uploaded in the EMAR system - had not documented client #3's psychotropic medications on the hard copy of the MAR - the pharmacy would not accept the FL2 for his psychotropic medications, therefore those medications were not in the EMAR system - client #3 did not miss his medications - during the EMAR system outage, staff #1 would contact her when client #3's medication was administered - she would document in the EMAR system medication was given - was trained during medication administration, the person that administer medications, documented the MARs - on 8/19/22 will write down all client #3's medications on a hard copy of a MAR	V 118		

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V 118	Continued From page 5 During interview on 8/22/22 the pharmacist reported: - had client #3's 8/8/22 FL2, which was accepted by his pharmacy - all client #3's medication had been inputted into the EMAR system by the pharmacy representative - it took time for the EMAR system to update with the medications entered - until all medications were uploaded into the EMAR system, staff needed to document the hard copies of the client MARS given by his pharmacy During interview on 8/23/22 the Licensee reported: - if the EMAR system was down, staff needed to initial the hard copy of the MARs - "moving forward, " staff will initial the hard copy of clients' MARs & the EMAR system "Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician"	V 118		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL051-203 Y1	A. Building B. Wing Y2	8/31/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAMILY CARE HOME	3310 NC 210 HWY SMITHFIELD, NC 27577

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0110 Reg. # 27G .0204 LSC	Correction Completed 08/31/2022	ID Prefix V0120 Reg. # 27G .0209 (E) LSC	Correction Completed 08/31/2022	ID Prefix V0291 Reg. # 27G .5603 LSC	Correction Completed 08/31/2022
ID Prefix V0318 Reg. # 13O .0102 LSC	Correction Completed 08/31/2022	ID Prefix V0367 Reg. # 27G .0604 LSC	Correction Completed 08/31/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Rhonda Smith	DATE 9/16/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/29/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: ZKHI12

ULTIMATE FAMILY CARE HOME INC.
817 SOUTH SECOND STREET
SMITHFIELD, NC 27577
Phone: (919) 880-3144. Fax: (919) 550-2163

September 21, 2022

Dear Ms. Smith,

Please see attached plan of correction for the deficiencies noted from the annual and follow up survey conducted on August 31, 2022 at our facility with MHL 051-203

Please feel free to email or call me at [redacted] with any questions.

Sincerely,

Administrator
Ultimate Family Care Home Inc.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

September 19, 2022

Lillian Okoro-Ezuma, Director
Ultimate Family Care Home Inc.
817 South Second Street
Smithfield, NC 27577

Re: Annual & Follow up Survey completed August 31, 2022
Ultimate Family Care Home, 3310 NC Highway 210, Smithfield, NC 27577
MHL #051-203
E-mail Address: ultimatehealthcare1@gmail.com

Dear Ms. Okoro-Ezuma:

Thank you for the cooperation and courtesy extended during the Annual & Follow up survey completed August 31, 2022.

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 deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 30, 2022.

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 Renee Kowalski at (919) 552-6847.

Sincerely,

Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Supervisor