STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/09/15.	C 000		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure all electrical, plumbing, and mechanical equipment in the facility was maintained in a safe and operating condition as related to maintaining lighting fixtures, toilets, a shower, and the washing machine. The findings are: Confidential interview with a resident revealed - The toilet in the main resident bathroom in the hallway keeps stopping up. - It has been messing up on and off for about 2 weeks. - A plumber came last week and it was fixed for about 4 days. - It got stopped up again yesterday. - Resident stated, "It's nasty". Confidential interview with a second resident revealed: - The toilet in the main resident bathroom in the hallway was stopped up.	C 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 102	Continued From page 1 - It had been that way since yesterday. Confidential interview with a third resident revealed: - The toilets in the main resident bathroom in the hallway and the staff bathroom had been stopped up for about 3 days. - These toilets had been overflowing/clogged 4 times this week. - A plumber came last week and worked on a sink because it was stopped up with hair. - Residents can use the bathroom in the laundry room if they need to. Observation of the main resident bathroom on 04/09/15 at 7:35 a.m. revealed: - The toilet was clogged with sewage which reached the brim of the toilet. - There was a 5-gallon bucket of brown-tinged water on the floor at right side of the toilet. - Three of 5 light bulbs were non-functioning in the overhead light fixture. Observation of the staff bathroom on 04/09/15 at 7:38 a.m. revealed: - The toilet was backed up/unusable. - There were 3 non-functioning bulbs in overhead light fixture. Observation of living room on 04/09/15 at 7:40 a.m. revealed: - There was no light fixture/lamp in the living room. - There was an small hole in the ceiling beam with indication of previous installation of ceiling light fixture. Observation of laundry room bathroom on 04/09/15 at 7:45 a.m. revealed: - Shower stall in bathroom was inoperable due	C 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 102	Continued From page 2	C 102		

to missing shower head attachment.
- There was loose debris on the shower floor.
- The toilet handle on the working toilet was hanging from connector socket on the bowl.
- The toilet handle required reinsertion into socket to flush toilet.

Interview with the Supervisor-in-Charge (SIC) on 04/09/15 at 8:00 a.m. revealed:
- The main resident toilet was currently clogged and plumber was notified on 04/08/15.
- The SIC reported this was caused by Resident #3's overuse of toilet paper.
- A plumber came to the facility the day before yesterday and "snaked" the toilet to get it unstopped.
- The SIC called the Administrator today about the toilet being stopped up again.
- The Administrator was supposed to get a plumber to come back to the facility today.
- The toilet has stopped up at least 3 times since she started working here on 03/16/15.
- She can sometimes use the plunger to unstop the toilet.
- A plumber has been twice to the facility since she started working here.
- The residents can use another bathroom located in the laundry room.
- The staff toilet is still clogged.
- The toilet in laundry room was functioning.
- The SIC stated the toilet in the laundry room can still be flushed but handle should be fixed.

Observation on 04/09/15 at 8:15 a.m. revealed there was a slow leak from base of washer forming puddle of water on linoleum floor.

Interview with SIC on 04/09/15 at 8:15 a.m. revealed:
- The SIC stated she was unaware of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 102	Continued From page 3	C 102		

washer leak.
- She stated she would inform the administrator and plumber who were expected today.

Telephone interview with the Administrator on 04/09/15 at 12:40 p.m. revealed:
- She got a call from the SIC this morning about the toilet being clogged up again.
- There was a resident cramming toilet paper in the toilet and stopping it up.
- The resident cut up and crammed a wig in the toilet last week and a plumber had to be called.
- It took two different plumbers last week to get it unstopped.
- She has called a plumber to come to the facility today to work on the problem.
- There was a staff bathroom and another bathroom in the laundry room that the residents can use if needed.
- She was unaware there was no lighting fixture in the living room.
- She stated there should be lamps in the living room.
- She was unaware the washing machine was leaking.
- It was a new washing machine and should not be leaking.

Interview with a plumbing service on 04/09/15 at 3:30 p.m. revealed:
- Receptionist stated they had been to the facility in the past but would not provide confirmation of visits this week nor any pending appointment today stating they would call back.
- No call back was received by the end of the survey.

Observation on 04/09/15 at 4:40 p.m. revealed no plumber had arrived on premises and the toilets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 102	Continued From page 4 were still clogged. Interview with unnamed plumber who entered the facility on 04/09/15 at 4:45 p.m. revealed: - He stated he was the plumber yet would not give his name or affiliation with any plumbing service. - He stated, "I'm the plumber, period and I'm here to fix everything."	C 102		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 2 staff (A, B) sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are:	C 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 140	Continued From page 5 1. Review of Staff A's personnel record revealed: - No hire date documented. - No documentation of any tuberculosis (TB) skin tests. Interview with Staff A on 04/09/15 at 11:35 a.m. revealed: - She started working at the facility on 03/16/15. - She had worked every day since then as the live-in Supervisor-in-Charge. - She worked 7 days a week, 24 hours a day. - She recalled one occasion the Administrator worked in her place for a couple of hours. - She could not recall which day. - She has not had any TB skin tests since being employed at the facility. - She was planning to go this Friday to get a TB skin test. - She recalled having a negative TB skin test "years ago" but she did not have any documentation of the TB skin test. Telephone interview with the Administrator on 04/09/15 at 12:55 p.m. revealed: - Staff A had been the live-in SIC 24 hours a day, 7 days a week, since she was hired. - Administrator would fill in if Staff A needed time off. - Staff A had a TB skin test in the past but could not provide any documentation. - Administrator was aware Staff A needed TB skin tests. - She reported they would get the TB skin tests done. 2. Review of personnel files in the facility revealed: - There was no personnel file for Staff B (Administrator/Owner).	C 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 140	Continued From page 6 - There was no documentation of any TB skin tests for Staff B. Interview with Staff A on 04/09/15 at 11:35 a.m. revealed she was unable to locate a personnel file for Staff B, the Administrator. Telephone interview with Staff B on 04/09/15 at 12:55 p.m. revealed she has her personnel file and would get it. No documentation regarding TB skin tests for Staff B was received.	C 140		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 1 facility non-licensed staff (A) had been competency validated by a licensed health professional for the monitoring and supervision of a resident who self-catheterized. The findings are:	C 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 171	Continued From page 7 Review of Staff A's personnel file revealed: - Hire date of 03/16/15. - Staff B was supervisor-in-charge (SIC) and medication aide. - No documentation of a Licensed Health Professional Support (LHPS) competency validation. Telephone interview with the Administrator on 04/09/15 at 12:55 p.m. revealed: - Staff A had been validated by the nurse for catheter care. - She was not sure where the documentation was located. - She would find it. Telephone interview with the facility's LHPS nurse on 04/09/15 at 4:15 p.m. revealed: - She has done some training for Staff A recently because a resident in the facility did self-catheterizations. - She would have left documentation at the facility. No documentation of LHPS validation for Staff A was provided. Observation of Resident #1's record on 04/09/15 at 10:00 a.m. revealed: - Order for self-catheterization with supervision. - Upcoming appointment in May 2015 for CBC (labwork) noted. Interview with SIC on 04/09/15 at 3:15 p.m. revealed: -SIC stated she was shown by the nurse how to do it but never was signed off on anything. -She stated Resident #1 usually calls her before he self caths.	C 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 171	Continued From page 8 -She monitored and supervised the resident to make sure he used clean supplies and did not contaminate the supplies.	C 171		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure at least one staff person on the premises at all times had completed a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, within the last 24 months for 1 of 1 staff (A) who worked and lived in the facility 24 hours a day, 7 days a week. The findings are: Review of Staff A's personnel record revealed:	C 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 176	Continued From page 9 - No hire date documented. - No documentation of any cardio-pulmonary resuscitation (CPR) training. Interview with Staff A on 04/09/15 at 11:35 a.m. revealed: - She started working at the facility on 03/16/15. - She had worked every day since then as the live-in Supervisor-in-Charge. - She worked 7 days a week, 24 hours a day. - She recalled one occasion the Administrator worked in her place for a couple of hours. - She could not recall which day. - She has not had any CPR training in over 20 years. - She could get the CPR training done this week. Telephone interview with the Administrator on 04/09/15 at 12:55 p.m. revealed: - Staff A had been the live-in SIC 24 hours a day, 7 days a week, since she was hired. - Administrator would fill in if Staff A needed time off. - She thought Staff A had CPR training but just needed to be recertified. - She could get the CPR instructor to do the training tomorrow. Review of the facility's plan of protection dated 04/09/15 revealed: - Staff A would get CPR certification/training on the next day, 04/10/15. - Staff will provide CPR certification upon hire. - CPR certifications will be filed in the facility. - Administrator will monitor staff personnel files at least monthly to assure CPR training is up-to-date and on file. - Administrator will assure CPR trained staff is	C 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 176	Continued From page 10 on-site at the facility at all times. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 24, 2015.	C 176		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 residents (#3) residing in the facility were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #3's current FL-2 dated 09/16/13 revealed a diagnosis of schizophrenia. Review of Resident #3's Resident Register revealed an admission date of 01/09/15. Review of Resident #3's record revealed: - Documentation on the FL-2 dated 12/04/14 noting a negative tuberculosis (TB) skin test on	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 11 07/19/14. - The date the TB skin test was placed was not documented. - No documentation of any other TB skin test. Telephone interview with the Administrator on 04/09/15 at 12:34 p.m. revealed: - The previous Supervisor-in-Charge tried to get Resident #3 to get a TB skin test but the resident would not go. - She did not know when staff tried to get the resident to go or if the SIC documented the refusal. - She would get the TB skin testing done for Resident #3. Based on observation and interview, Resident #3 was at a day program and unavailable for interview.	C 202		
C 316	10A NCAC 13G .1002(b) Medication Orders 10A NCAC 13G .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure all medication orders were in the residents' records for 1 of 3 residents (#3) sampled including orders to administer antipsychotic and sleep medications and orders to hold antipsychotic and antianxiety medications for a resident with auditory and visual hallucinations. The findings are: Review of Resident #3's record revealed: - Diagnosis on the current FL-2 dated 12/04/14	C 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 316	Continued From page 12	C 316		

included schizophrenia.
- The resident was admitted to the facility on 01/09/15.

A. Review of the April 2015 medication administration records (MARs) revealed:
- Risperdal Consta 50mg intramuscularly every 2 weeks was documented as administered to the resident on 04/07/15. (Risperdal Consta is a long-acting antipsychotic injection.)
- Thorazine 100mg, 1 and ½ tablets (150mg) was documented as administered 3 times a day at 8:00 a.m., 12:00 noon, and 5:00 p.m. (Thorazine is an oral antipsychotic medication.)
- Melatonin 3mg was documented as administered daily at 8:00 p.m. (Melatonin is a hormone used to regulate sleep.)

Review of Resident #3's record revealed:
- There was no order for Risperdal Consta.
- There was no order for Thorazine.
- There was no order for Melatonin.
- There was no MARs prior to April 2015 in the resident's record.

Interview with the Supervisor-in-Charge (SIC) on 04/09/15 at 12:00 noon revealed:
- She did not realize there was no orders for these medications in Resident #3's record.
- She gave medications according to what was transcribed on the MARs.
- SIC did not receive or handle any medication orders.
- The Administrator received medication orders and brought the orders to the facility to transcribe the orders.
- She did not know where the previous months' MARs were filed since she was new.
- She recalled documenting on the MARs since she started on 03/16/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 316	Continued From page 13 - She would check with the Administrator to help find the documentation. - SIC stated Resident #3 heard voices and would have conversations with people who are not there. Telephone interview with the Administrator on 04/09/15 at 12:34 p.m. revealed: - She did not know why these medication orders or previous MARs were not in the resident's record. - She thought a previous employee may have filed some paperwork but she was unable to access that information currently. - She stated she would get those orders. - She stated Resident #3 got paranoid at times. Telephone interview with a pharmacist at the primary pharmacy on 04/09/15 at 2:13 p.m. revealed: - They pharmacy had orders on file for Risperdal Consta, Thorazine, and Melatonin. - If a physician faxes an order to the pharmacy, the pharmacy will fax a copy to the facility for the resident's record. - Their records indicted these orders were faxed to the pharmacy from another facility associated with the Administrator. - Since these orders were faxed to the pharmacy by the Administrator, not the physician, the pharmacy would not have needed to fax a copy to the facility. - The pharmacist stated she would fax copies of the orders for these medications that were on file at the pharmacy. Review of physician's orders faxed by the pharmacy on 04/09/15 revealed: - Order dated 02/20/15 for Risperdal Consta 50mg every 2 weeks.	C 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 316	Continued From page 14 - Order dated 01/17/15 for Thorazine 150mg 3 times daily. - Order dated 01/17/15 for Melatonin 3mg at bedtime. B. Interview with Resident #3 on 04/09/15 at 7:40 a.m. revealed: - She goes to a day program Monday through Friday from about 8:00 a.m. - 4:30 p.m. - She did not take any medications at the day program. - She took her morning medications before she left to go to the day program each morning. - She felt like her medications made her sleepy. Review of the April 2015 medication administration record (MAR) revealed: - Thorazine 100mg, 1 and ½ tablets (150mg) was documented as administered 3 times a day at 8:00 a.m., 12:00 noon, and 5:00 p.m. (Thorazine is an oral antipsychotic medication.) - Ativan 2mg was documented as administered 3 times daily at 8:00 a.m., 12:00 noon, and 5:00 p.m. (Ativan is used to treat anxiety.) Review of the April 2015 controlled substance log for Ativan for Resident #3 revealed: - Twenty-three doses of Ativan were documented as administered from 04/01/15 - 04/09/15. - 12:00 noon doses were documented as administered twice on 04/03/15 (Friday), once on 04/04/15 (Saturday), and once on 04/05/15 (Sunday). - No other 12:00 noon doses were documented. Interview with the Supervisor-in-Charge (SIC) on 04/09/15 at 11:15 a.m. revealed: - She did not usually give the 12:00 noon doses of Thorazine or Ativan because the resident was	C 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 316	Continued From page 15	C 316		

usually at the day program at that time.
- She usually only administered the 12:00 noon doses of these two medications on the weekends.
- She did not send the medications with the resident to the day program.
- She thought there might be a nurse at the day program who gave medications to the residents there.
- She could not explain why she documented the 12:00 noon doses of these two medications as administered even though she was not administering these medications at that time.
- SIC stated Resident #3 heard voices and would have conversations with people who are not there.

Telephone interview with the Administrator on 04/09/15 at 12:34 p.m. revealed:
- She did not realize the Ativan and Thorazine were scheduled to be administered at 12:00 noon.
- She stated they should be scheduled to be administered at 8:00 a.m., 3:00 p.m., and 8:00p.m. so the resident could get the 3:00 p.m. dose when she returned from the day program.
- She then stated she thought the medications could be held while resident was at the day program.
- She stated she would check with the physician about holding these medications.

Telephone interview with a receptionist at the mental health physician's office on 04/09/15 at 1:37 p.m. revealed the physician was unavailable for interview but she would have someone call back.

Telephone interview with an employee at Resident #3's day program on 04/09/15 at 3:25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 316	Continued From page 16	C 316		

p.m. revealed:
- She had not given any medications to any residents at the day program.
- She was not aware of any residents receiving medications at the day program.

Telephone interview with the facility nurse on 04/09/15 at 4:15 p.m. revealed:
- She volunteered as a nurse at the mental health physician's office for Resident #3.
- The physician was aware of Resident #3's psychoses.
- Physician was aware of Resident #3 not getting the 12:00 noon medications because the resident sometimes got a little lethargic.
- She would locate and fax an order to hold the 12:00 noon medications.

Review of Resident #3's record revealed:
- There was no order to hold any doses of Thorazine.
- There was no order to hold any doses of Ativan.

Telephone interview with a pharmacist at the primary pharmacy on 04/09/15 at 2:13 p.m. revealed:
- They pharmacy had orders on file for Thorazine and Ativan.
- The pharmacist stated she would fax copies of the orders for these medications that were on file at the pharmacy.

Review of physician's orders faxed by the pharmacy on 04/09/15 revealed there were no orders for Thorazine or Ativan to be held.

Review of a fax from the facility on 04/10/15 revealed a telephone order dated 01/12/15 to hold Thorazine and Ativan during day program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure medication administration records were accurate and complete for 1 of 3 residents (#3) sampled as related to staff documenting the administration of antipsychotic and antianxiety medication at 12:00 noon even though the resident was not receiving those medications at that time. The findings are: Review of Resident #3's record revealed: - Diagnosis on the current FL-2 dated 12/04/14 included schizophrenia. - The resident was admitted to the facility on	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 18 01/09/15. Review of the April 2015 medication administration record (MAR) revealed: - Thorazine 100mg, 1 and ½ tablets (150mg) was documented as administered 3 times a day at 8:00 a.m., 12:00 noon, and 5:00 p.m. (Thorazine is an oral antipsychotic medication.) - Ativan 2mg was documented as administered 3 times daily at 8:00 a.m., 12:00 noon, and 5:00 p.m. (Ativan is used to treat anxiety.) Review of Resident #3's record revealed: - Order on the current FL-2 dated 12/04/14 for Ativan 2mg 3 times daily. - There was no order for Thorazine. - There was no MARs prior to April 2015 in the resident's record. Interview with Resident #3 on 04/09/15 at 7:40 a.m. revealed: - She goes to a day program Monday through Friday from about 8:00 a.m. - 4:30 p.m. - She did not take any medications at the day program. - She took her morning medications before she left to go to the day program each morning. Review of the April 2015 controlled substance (CS) log for Ativan for Resident #3 revealed: - Twenty-three doses of Ativan were documented as administered from 04/01/15 - 04/09/15. - Documentation on the CS log did not match documentation on the MARs for the administration of the 12:00 noon doses of Ativan. - 12:00 noon doses were documented as administered twice on 04/03/15 (Friday), once on 04/04/15 (Saturday), and once on 04/05/15 (Sunday).	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 19 - No other 12:00 noon doses were documented on the CS log. Interview with the Supervisor-in-Charge (SIC) on 04/09/15 at 11:15 a.m. revealed: - She did not usually give the 12:00 noon doses of Thorazine or Ativan because the resident was usually at the day program at that time. - She usually only administered the 12:00 noon doses of these two medications on the weekends. - She did not send the medications with the resident to the day program. - She thought there might be a nurse at the day program who gave medications to the residents there. - She could not explain why she documented the 12:00 noon doses of these two medications as administered on the MARs even though she was not administering these medications at that time. - She did not know where the previous months' MARs were filed since she was new. - She recalled documenting on the MARs since she started on 03/16/15. - She would check with the Administrator to help find the documentation. Telephone interview with the Administrator on 04/09/15 at 12:34 p.m. revealed: - Administrator checked the MARs monthly per facility policy. - She did not realize the Ativan and Thorazine were scheduled to be administered at 12:00 noon. - She stated they should be scheduled to be administered at 8:00 a.m., 3:00 p.m., and 8:00p.m. so the resident could get the 3:00 p.m. dose when she returned from the day program. - She was unaware staff was documenting the 12:00 noon doses of Ativan and Thorazine as	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 20 being administered. - She then stated she thought the medications could be held while resident was at the day program. - She did not know why the previous MARs were not in the resident's record. - She thought a previous employee may have filed some paperwork but she was unable to access that information currently. - She stated she would get previous MARs. Telephone interview with the facility nurse on 04/09/15 at 4:15 p.m. revealed: - She volunteered as a nurse at the mental health physician's office for Resident #3. - Physician was aware of Resident #3 not getting the 12:00 noon medications because the resident sometimes got a little lethargic. Review of Resident #3's record revealed: - There was no order to hold any doses of Thorazine. - There was no order to hold any doses of Ativan.	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure a readily	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 21	C 367		

retrievable record in order to accurately reconcile controlled substances for 1 of 3 residents (#3) sampled for a controlled substance used to treat anxiety. The findings are:

Review of Resident #3's current FL-2 dated 12/04/14 revealed:
- Diagnosis of schizophrenia.
- Order for Ativan 2mg 3 times a day. (Ativan is used to treat anxiety.)

Review of the April 2015 medication administration record (MAR) revealed:
- Ativan 2mg was documented as administered 3 times daily at 8:00 a.m., 12:00 noon, and 5:00 p.m.
- Twenty-five doses were documented as administered from 04/01/15 - 04/09/15.

Record review revealed there was no March 2015 MAR available for review in the facility.

Review of the April 2015 controlled substance (CS) log for Ativan for Resident #3 revealed:
- Pharmacy label on the CS log indicated this supply of Ativan was dispensed on 04/01/15 with 90 tablets.
- First documented dose from this supply was 04/01/15 at 8:00 a.m.
- Twenty-three 90 doses of Ativan were documented as administered from 04/01/15 - 04/09/15.
- Documentation on the CS log did not match documentation on the MARs for the administration of the 12:00 noon doses of Ativan.
- 12:00 noon doses were documented as administered twice on 04/03/15 (Friday), once on 04/04/15 (Saturday), and once on 04/05/15 (Sunday) for a total of four 12:00 noon doses.
- This did not match the eight 12:00 noon doses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 22	C 367		

documented on the April 2015 MAR.
- The 8:00 a.m., 12:00 noon, and 8:00 p.m. doses for 04/03/15 were documented twice each on the CS log.
- The CS log indicated 67 Ativan 2mg tablets was the amount remaining.

Observation of medications on hand revealed:
- One supply of Ativan 2mg tablets dispensed on 03/01/15 with 2 of 93 tablets remaining.
- One supply of Ativan 2mg tablets dispensed on 04/01/15 with all 90 tablets remaining.
- There was a total of 92 Ativan 2mg tablets on hand, not 67 as indicated on the CS log.

Review of Resident #3's record revealed no other controlled substance logs available for review.

Telephone interview with a pharmacist at the primary pharmacy on 04/09/15 at 2:13 p.m. revealed 93 Ativan 2mg tablets were dispensed on 03/01/15 and 90 tablets on 04/01/15.

Interview with the Supervisor-in-Charge (SIC) on 04/09/15 at 11:15 a.m. revealed:
- She did not usually give the 12:00 noon dose Ativan because the resident was usually at the day program at that time.
- She usually only administered the 12:00 noon dose of Ativan on the weekends.
- She did not send the medications with the resident to the day program.
- She thought there might be a nurse at the day program who gave medications to the residents there.
- She could not explain why she documented the 12:00 noon dose of Ativan as administered on the April 2015 MAR even though she was not administering the Ativan at that time.
- She was unable to locate any MARs or CS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 23 logs prior to April 2015. - She was unsure why the quantity remaining on the CS log did not match the amount of Ativan on hand. Telephone interview with the Administrator on 04/09/15 at 12:34 p.m. revealed: - Administrator usually reviewed the CS logs for accuracy monthly per facility policy. - She did not realize the Ativan was scheduled to be administered at 12:00 noon. - She was unaware the CS log did not match the MAR or the quantity of Ativan on hand. - She did not know why the other MARs and CS logs were not on file at the facility in the resident's record. - She thought a previous employee may have filed some paperwork but she was unable to access that information currently.	C 367		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to training on cardio-pulmonary resuscitation. The findings are:	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 24 Based on record review and interview, the facility failed to assure at least one staff person on the premises at all times had completed a course on cardio-pulmonary resuscitation (CPR) and choking management, including the Heimlich maneuver, within the last 24 months for 1 of 1 staff (A) who worked and lived in the facility 24 hours a day, 7 days a week. [Refer to Tag C176 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation).]	C 912		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(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
C992	Continued From page 25 psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure examination and screening for the presence of controlled substances were performed for 1 of 1 staff (A) that was hired after 10/01/13. The findings are: Review of Staff A's personnel record revealed: - No hire date documented. - No documentation of a controlled substance examination and screening. Interview with Staff A on 04/09/15 at 11:35 a.m. revealed: - She started working at the facility on 03/16/15. - She had worked every day since then as the live-in Supervisor-in-Charge. - She worked 7 days a week, 24 hours a day. - She recalled one occasion the Administrator worked in her place for a couple of hours. - She could not recall which day. - She has not had a urine drug screening. Telephone interview with the Administrator on 04/09/15 at 12:55 p.m. revealed: - Staff A had been the live-in SIC 24 hours a day, 7 days a week, since she was hired.	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL040006	A. BUILDING: _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIE'S FAMILY CARE HOME	1025 POPE FARM ROAD STANTONSBURG, NC 27883

(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
C992	Continued From page 26 - Administrator would fill in if Staff A needed time off. - The Administrator was aware of the requirement of urine drug screening for staff. - Staff A had no urine drug screening yet because the Administrator knew Staff A did not use drugs.	C992		