STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL064019	A. BUILDING: _____ B. WING _____	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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 July 12, 2016.	C 000		
C 073	10A NCAC 13G .0314 (c) Floors 10A NCAC 13G .0314 Floors (c) All floors shall be kept in good repair This Rule is not met as evidenced by: Based on interviews and observation, the facility failed to assure the floor was kept in good repair in the living room, resident bedroom #1 and the hallway entry. The findings are: Observation of the floor at the living room on 7/12/16 at 9:00am revealed 4-foot round area which sank approximately 2-inches at the center when walking across the area. Observation of the floor at the center of resident room #1 on 7/12/16 at 9:00am revealed 2-foot round area which sank approximately 2-inches at the center when walking across the carpet. Observation of the hallway floor in front of the bathroom on 7/12/16 at 9:10am revealed a 2-inch by 4-inch hole in the wood flooring. Interview with the facility's 3 residents on 7/12/16 at 9:45am revealed that they were not bothered by the depressions in the floor. Interview with the Administrator on 7/12/16 at 9:15am revealed: -He was aware that the living room floor sank when walked on. -He was unaware that the center of the carpet in resident room #1 sank when walking across the	C 073		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL064019	A. BUILDING: _____ B. WING _____	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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 073	Continued From page 1 carpet. -He was aware of the hole in the floor in the hallway. -The county construction inspector had cited the living room floor two months ago. -He was trying to find someone to make the needed repairs. -The residents had not complained about the floors. -He would ensure that the floors were repaired promptly.	C 073		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair. The findings are: Observation of the facility on 7/12/16 between 7:00am and 9:30am revealed: -The wooden handicap ramp at the front entrance of the facility had multiple raised nails protruding from the top of the wooden handrails on each side of the ramp. -The wooden handicap ramp at the side entrance of the facility had multiple raised nails protruding from the top of the wooden handrails on each side of the ramp.	C 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL064019	A. BUILDING: _____ B. WING _____	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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 074	Continued From page 2 -Both ramps had peeling brown paint chips throughout the entire length. -The hallway had an 8-foot section of peeling wallpaper border at the ceiling. -The hallway wall had a 3-foot horizontal tear in the wallpaper 8-inches above the baseboard. -The light switch plates in the family room, kitchen, bathroom, hallway and 3 resident rooms were covered in a brownish grime. -The ceiling in the family room had a 3-foot long grey stain along the ceiling border above the sliding glass door. -There was a missing outlet with a missing cover plate in the hallway. -The wooden front door frame molding was cracked and splintered. -The common-use bathroom shower had black stains on the wall above and below the metal handrail. -There was a 2-foot length of rusted exposed metal area along the edge of the tub below the faucet knobs. -The refrigerator and freezer doors had multiple rust spots extending 3 feet above the floor. -The refrigerator door handles were sticky and covered in a brown grime. Confidential interviews with all residents revealed: -They were not bothered by the current condition of the facility. -The facility needed "some upkeep." -They enjoyed living at the facility. Interview with the Administrator on 7/12/16 at 10:50am revealed: -The Administrator was aware there were areas of repair to address. -He was the one who facilitated repairs. -The Administrator was already addressing previously cited areas in need of repair identified	C 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL064019	A. BUILDING: _____ B. WING _____	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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 074	Continued From page 3 by the Department of Social Services (DSS) which included the ramps and the living room floor. -DSS had visited the facility two months ago. -Many of the areas in need of repair were previously cited already by DSS. -There was no policy for regular maintenance for anything in the facility. -He would immediately arrange for someone to repaint and repair the flooring, ramps and walls. -He was already "in the process" of finding someone to repair the previously cited areas. -He was unable to state a plan of action for repairs to the facility. -The facility did not have a maintenance man. -None of the residents had complained about the facility's condition.	C 074		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	C 934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL064019	A. BUILDING: _____ B. WING _____	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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 934	Continued From page 4 This Rule is not met as evidenced by: Based on interviews, employee record reviews, the facility failed to assure 3 of 3 sampled medication aides (Staff A, B and C) had completed the state mandated infection control course. The findings are: 1. Review of Staff A's employee records revealed: -A hire date of 7/6/06. -Job title was Administrator/Medication Aide. -No state-mandated annual infection control course certificate was available. Refer to interview with Administrator on 7/12/16 at 10:30am. 2. Review of Staff B's employee records revealed: -A hire date of 12/1/98. -Job title was Medication Aide -No state-mandated annual infection control course certificate was available. Staff B was unavailable for interview. 3. Review of Staff C's employee records revealed: -A hire date of 11/5/01. -Job title was Medication Aide -No state-mandated annual infection control course certificate was available. Staff C was unavailable for interview. Interview with Administrator (Staff A) on 7/12/16 at 10:30am revealed: -He did not know there was a state-mandated infection control course.	C 934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL064019	A. BUILDING: _____ B. WING _____	07/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIGHT'S FAMILY CARE HOME # 2	312 CLEO STREET ROCKY MOUNT, NC 27801

(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 934	Continued From page 5 -He could not remember an infection control course previously given at the facility by the nurse. -He did not know it was required yearly for medication aides. -He did not know it was required for all employees upon hire. -He provided training information to all staff. -The facility's nurse would be contacted immediately to set up a training date for infection control. -He would ensure all staff get mandated training per the state rules.	C 934		