STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 September 12, 2017.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 007	Continued From page 1 building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the number of residents in the 5 bed licensed facility did not exceed the licensed capacity of 5. The findings are: Observation of the facility on 09/12/17 at 7:30 AM revealed there were 6 residents at the facility. Review of the facility's license revealed the facility was licensed to have five ambulating residents. Observation of the facility on 09/12/17 at 7:05 AM revealed: -There were six resident beds in the facility. -All six beds appeared to have linens on them and a residents personal belongings beside them. Interview with all 6 residents at the facility on 09/12/17 from 7:18 AM to 7:28 AM revealed: -All the residents said they had been living at the facility for a long time. -None of them could give exact dates but the ranges were from 3 to 8 years at the facility. Interview with a Medication Aide on 09/12/17 at 8:00 AM revealed: -There were six residents living in the facility. -All six of them had been at the facility for at least a few years now. -She was not aware that the facility was only licensed for 5 residents.	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 007	Continued From page 2 Interview with the Administrator on 09/12/17 at 8:58 AM revealed: -She had brought over a 6th resident a few weeks ago due to a staffing issue at another one of her facilities. -The resident was a female that does not like male staff and her female staff for that facility was going to be out a few weeks for emergency reasons. -The new resident had been at this facility for about 3 weeks. -She planned on moving this resident back in about a week when the female staff worker returned to that facility. -She was aware that she was not to exceed her licensed capacity of residents. -She thought that it would be ok since it was an issue with her staffing at the other facility. -She would make sure the resident was moved back as soon as possible.	C 007		
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 that walls, ceiling, and floors were kept in good repair including black fuzzy spots on a bathroom ceiling and floors that would flex when walked on.	C 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 The findings are: Observation of a full size bathroom at the facility on 09/12/17 at 10:05 AM revealed: -The floor in front of the tub would flex and sink down when walked on. -There was a tear about 12 inches long in the floor of the bathroom that exposed the sub-flooring. -There was a broken towel rack and broken toilet paper holder on the wall of the bathroom. -There was a small hole in the wall about the size of a dime beside the toilet. -The floor on each side of the toilet and behind the toilet dipped downward. Observation of a half bathroom at the facility on 09/12/17 at 10:15 AM revealed: -The ceiling in the bathroom had 3 large dried spots that were black and fuzzy. -The ceiling had one large dried spot in the center that was a light orange color. Observation of the main hallway of the facility on 09/12/17 at 10:18 AM revealed there were two large holes one about the size of a quarter and the other about the size of a baseball that exposed some sheet rock and plaster. Interview with the Administrator on 09/12/17 at 10:20 AM revealed: -She was not aware of the black spots on the ceiling of the half bathroom. -The towel racks and tolilet paper hodlers in the bathroom had been broken for about a month and she had been meaning to get them fixed. -She did know the floor was flexing and sinking down. -She had the floor repaired a while back, but was	C 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 4 not sure when that was done. -She would call her maintenance man today 09/12/17 to come and look at repairing all the problems with the facility.	C 074		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that 1 of 3 sampled residents (Resident #3) had an FL-2 completed annually. The findings are: Review of Resident #3's current FL-2 dated for 02/11/16 revealed diagnosis of hypertension, mental retardation, and anemia. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 01/01/16. Based on observations, interviews, and record reviews Resident #3 was not interview-able. Interview with the Administrator on 09/12/17 at 9:10 AM revealed: -She had completed a new FL-2 for Resident #3	C 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 203	Continued From page 5 but she was not sure where it was located. -She had completed it the same day that the new care plan was updated which was 01/26/17. -She would continue to look for the FL-2 to see if she could find it. -If she was unable to find the FL-2 then she would call the primary care provider and have a new FL-2 completed for Resident #3. -She was aware that a new FL-2 was required to be completed annually. -She was responsible for making sure that all FL-2's were completed.	C 203		
C 292	10A NCAC 13G .0905 (d) Activities Program 10A NCAC 13G .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that at least 14 hours of planned activities were scheduled on the activity calendar for residents to participate.	C 292		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 292	Continued From page 6 The findings are: Observation of the activity calendar on 09/12/17 revealed: -There was no activity calendar hanging on the wall. -There was an old calendar laying on top of the reach in freezer in the dining room that was dated for August 2016. -There appeared to be 20 plus hours of planned activities on this calendar. -Most of the activities were scheduled in the evenings due to a daily scheduled day program. Observation of the facility on 09/12/17 from 7:00 AM to 8:15 AM revealed: -There were no activities offered to any of the six residents. -All six residents left around 8:15 AM to go to a day program for the day. Interview with all 6 residents at the facility on 09/12/17 from 7:18 AM to 7:28 AM revealed: -The only activity that was being offered to them was there day program they attended every day. -Sometimes they would watch television at night time at the facility. -They did go out to eat on occasions but most of the time that was only around the holidays. -No other activities were being offered that they were aware of. Interview with the Administrator on 09/12/17 at 9:40 AM revealed: -She was licensed to set up and provide activities for the residents. -The staff were responsible for making sure the calendar was put up each month. -Sometimes she would make the calendar and	C 292		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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 292	Continued From page 7 sometimes she would have the staff make the calendar. -She was not aware until today 09/12/17 that the calendar had not been done. -There was no one assigned to post the calendar, it was the responsibility of all staff to make sure it was done. -She was responsible for making sure staff had posted the calendar. -The residents get activities just about every day. -She thought they were required only to have 8 hours of planned activities per week. -She would make sure the activity calendar was completed and posted.	C 292		
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	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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
C992	Continued From page 8 controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or 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 interviews and record reviews the facility failed to assure that 2 of 3 sampled staff (Staff B and Staff C) had completed a drug screen prior to working at the facility. The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired at the facility on 06/06/17 as a Personal Care Aide. -There was no documentation that a drug screen had been completed for Staff B. Telephone interview with Staff B on 09/12/17 at 9:30 AM revealed: -She had been hired at the facility sometime in June of 2017, but was not sure of the exact date. -She had not completed a drug screen. -She was not aware that one had to be completed in order to work at the facility. Refer to interview with the Administrator on 09/12/17 at 9:20 AM.	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	09/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL 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
C992	Continued From page 9 2. Review of Staff C's personnel file revealed: -Staff C was hired at the facility on 07/23/17 as a Personal Care Aide. -There was no documentation that a drug screen had been completed for Staff C. Telephone interview with Staff C on 9/12/17 at 9:25 AM revealed: -She had been hired at the facility sometime in July 2017, but was not sure of the exact date. -She had not completed a drug screen. -She was not aware that one had to be completed in order to work at the facility. Interview with the Administrator on 09/12/17 at 9:20 AM revealed: -She had not had Staff B and Staff C complete a drug screen. -She was not aware that Staff B and Staff C were required to complete a drug screen prior to working at the facility. -She was responsible for making sure all staff qualifications were completed. -She would make sure that Staff B and Staff C completed a drug screen as soon as possible.	C992		