

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL032142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/26/2017
NAME OF PROVIDER OR SUPPLIER SUPREME FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 BENNING STREET DURHAM, NC 27703		
(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 October 26, 2017.	C 000		
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director, as required in Rule .0404 of this Subchapter, shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.	C 291		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL032142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/26/2017
NAME OF PROVIDER OR SUPPLIER SUPREME FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 BENNING STREET DURHAM, NC 27703		
(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 291	Continued From page 1 This Rule is not met as evidenced by: Based on observations and interviews the facility failed to assure that 14 hours of planned activities each week were being provided to all residents. The findings are: Observation of the activity calendar on 10/26/17 at 9:30 AM revealed: -The activity calendar that was displayed was the calendar from July 2017 with 22 hours per week of planned activities. -There were bible studies, movies, current events, and -There were no activities scheduled until after 4:00 PM. Interview with 3 residents at the facility on 10/26/17 from 8:30 AM to 9:00 AM revealed: -They were not being offered activities at the facility. -They did go on outings once every few weeks. -They went to a day program Monday thru Friday. -There were no activities at the facility except for watching television or walking around outside. Interview with the Supervisor in Charge on 10/26/17 at 10:25 AM revealed: -Activities such as movies and games were done once a week and not every day. -The resident had television time every night. -The facility also offered some exercise activities for the residents every week. -The staff did not follow the activity calendar when doing activities. Interview with the Administrator on 10/26/17 at 11:10 AM revealed: -Activities were done every day at the facility.	C 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL032142	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/26/2017
NAME OF PROVIDER OR SUPPLIER SUPREME FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 BENNING STREET DURHAM, NC 27703		
(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 291	Continued From page 2 -The facility offered games, movies, and walks. -The Activities Director made the calendars and sends them to the facility. -They had a year at a time done. -The Administrator is responsible for making sure the calendar was changed each month. -The calendar for October had been completed she had just forgotten to change it. -The calendar was usually the same each month and that is why she forgot to change it. -She would make sure the calendar was changed as soon as possible and that it got changed monthly from now on.	C 291		