STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092219	A. BUILDING: _____ B. WING _____	05/22/2019

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CARY FAMILY CARE	545 FRONT RIDGE DRIVE CARY, NC 27519

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C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on May 22, 2019.	C 000		
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 reviews and interviews, the facility failed to assure 2 of 3 residents sampled (Residents #1 and #3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 03/20/19 revealed diagnoses included dementia, gastroesophageal reflux disease, anxiety, allergies, pseudobulbar affect, insomnia and bradycardia. Review for Resident #1's record revealed: -There was documentation that a TB test was administered on 02/14/18 and read as negative	C 202		

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on 02/16/18.
-There was no documentation a second step TB test was administered since Resident #1 was admitted to the facility on 02/26/18.

Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.

Interview with the Administrator on 05/22/19 at 10:53am revealed:
-He was not aware Resident #1 did not have a second step TB test done.
-He was responsible to ensure the second step TB was administered.

2. Review of Resident #3's current FL-2 dated 08/29/18 revealed diagnoses included dementia, acute renal failure, cystitis, and muscle weakness.

Review of Resident #3's record revealed:
-Resident #3 was admitted to the facility on 09/10/18.
-There was documentation that a TB test was administered on 08/29/18 and read as negative on 08/31/18.
-There was no documentation of a second step TB test was administered since Resident #3 was admitted at the facility.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

Interview with the Administrator on 05/22/19 at 12:30pm revealed:
-Resident #3 was admitted from another facility on 09/10/18.
-He thought Resident #3 had both of her TB skin

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C 202	Continued From page 2 tests at the previous facility. -He was not sure if Resident #3 had any TB skin test prior to 08/29/18. -Resident #3 had not had a second step TB skin test since she was admitted. -He was responsible for ensuring the residents had their two-step TB skin test completed.	C 202		
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Resident Registers were completed for 3 of 3 sampled residents (Resident #1, #2, and #3) within seventy-two hours of admission. The findings are: 1. Review of Resident #1's current FL-2 dated 03/20/19 revealed diagnoses included dementia, gastroesophageal reflux disease, anxiety,	C 212		

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allergies, pseudobulbar affect, insomnia and bradycardia.

Review of Resident #1's Resident Register revealed:
-Resident #1 was admitted to the facility on 02/26/18.
-There was no signature by the resident or the resident's responsible person.

Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.

Interview with the Administrator on 05/22/19 at 10:45am revealed:
-He forgot to have the Resident Register signed by the resident or Resident #1's responsible party.
-He was responsible to ensure the Resident Registers were completed.

2. Review of Resident #2's current FL-2 dated 07/17/18 revealed diagnoses included cerebrovascular accident, Parkinson's disease, major depressive disorder, weakness, hypertension, coronary artery disease, traumatic head injury, hyperlipidemia, and osteoporosis.

Review of Resident #2's record on 05/22/19 revealed:
-Resident #2's record contained only an unsigned fourth page of a Resident Register with a blue plastic flag marker on it.
-There was no completed Resident Register available for review.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

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C 212	Continued From page 4 Interview with the Administrator on 05/22/19 at 12:45pm revealed: -He needed to complete a Resident Register for Resident #2. -He did not realize the Resident Register was missing pages. -He had 'flagged' the form for Resident #2's family to sign when she was admitted but he forgot to get the family to sign it. -He would get a new Resident Register form and get her family to sign it on their next visit. -He was responsible for making sure all required paperwork was completed upon admission for the residents. 3. Review of Resident #3's current FL-2 dated 08/29/18 revealed diagnoses included dementia, acute renal failure, cystitis, and muscle weakness. Review of Resident #3's record revealed there was no Resident Register available for review. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Interview with the Administrator on 05/22/19 at 12:45pm revealed: -He did not know Resident #3 did not have a Resident Register in her record. -He just "forgot" about completing the Resident Register since he "was focused on her care". -He would complete the form and get her family to sign it on their next visit. -He was responsible for making sure all required paperwork was completed upon admission for the residents.	C 212		

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C 254	Continued From page 5	C 254		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure that the licensed health professional support (LHPS) evaluations were completed quarterly for 3 of 3 sampled residents for the tasks of transferring assistance for semi- ambulatory and non-ambulatory residents (Resident #1 and #2) including the use of a hoyer lift (Resident #2), ambulation using assistive devices that required physical assistance (Resident #1 and Resident	C 254		

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#2), feeding techniques for residents with swallowing problems (Resident #1, #2. and #3), the use of suppositories (Resident #2), and inhalation medication by machine (Resident #2).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/20/19 revealed diagnoses included dementia, gastroesophageal reflux disease, anxiety, allergies, pseudobulbar affect, insomnia, bradycardia and Resident #1 was non-ambulatory.

Review of Resident #1's LHPS evaluations and quarterly reviews revealed:
-The LHPS evaluation was completed on 02/28/18 and 06/12/18 with tasks for transferring assistance for semi-ambulatory and non-ambulatory residents, feeding techniques for residents and ambulation using assistive devices that required physical assistance.
-There were no LHPS quarterly reviews for Resident #1 after 06/12/18.

Observation of Resident #1 on 05/22/19 at 10:07am and 11:30am revealed:
- Resident #1 used a wheelchair and the Administrator assisted Resident #1 with using the wheelchair in the facility.
-The Administrator monitored Resident #1 during meal and snack times.

Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.

Interview with the Administrator on 05/22/19 at 10:53am revealed:
-He was not aware the LHPS needed to be

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updated quarterly for Resident #1.
-The previous LHPS nurse had resigned several months ago (time not specified) and was no longer available.
-Resident #1 was assisted with ambulation by holding their hand.
-Resident #1 was assisted with transfer from bed to wheelchair.
-Resident #1 could eat without assistance but the Administrator observed to prevent choking.

2. Review of Resident #2's current FL-2 dated 07/17/18 revealed:
-Diagnoses included cerebrovascular accident, Parkinson's disease, major depressive disorder, weakness, hypertension, coronary artery disease, traumatic head injury, hyperlipidemia, and osteoporosis.
-Resident #2 was semi-ambulatory.
-Resident #2 had a regular mechanical soft diet and required constant supervision while eating.

Review of Resident #2's current care plan dated 07/25/18 revealed:
-Resident #2 was sometimes disoriented, forgetful, and needed reminders.
-Resident #2 was ambulatory with assistive devices.
-Resident #2 used a walker and a wheelchair.
-Resident #2 was totally dependent for ambulation and transferring.
-Resident #2 had a history of dysphagia and was on a regular mechanical soft diet.
-Resident #2 required constant supervision while eating.
-Resident #2 required extensive assistance with eating.

Review a Resident #2's record revealed a hospice coordinated task form that revealed the

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use of a hoyer lift with Resident #2 that started 03/12/19.

Review of medication orders for Resident #2 revealed:
-There was a medication order dated 04/02/19 for Bisacodyl 10mg suppository daily as needed for constipation (Bisacodyl is a medication used to treat constipation).
-There was medication order dated 04/04/19 for Combivent 0.5mg/3ml - 1 vial four times a day as needed for shortness of breath and wheezing via nebulizer (Combivent is a medication used to treat breath problems such a shortness of breath and wheezing).

Review of Resident #2's LHPS evaluation and quarterly reviews revealed:
-There was LHPS evaluation completed on 07/25/18 with tasks for transferring semi-ambulatory or non-ambulatory residents, ambulation using assistive devices that requires physical assistance, and feeding techniques for residents with swallowing problems.
-There were no LHPS quarterly reviews for Resident #2.

Observation of Resident #2's room on 05/22/19 at 9:55am revealed:
-There was a hoyer lift at the foot of Resident #2's bed and wheelchair with a gait belt draped over it on the left side of her room.
-There was a nebulizer machine on a bedside table at the head of Resident #2's bed on the left.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Observation of Resident #2 on 05/22/19 at

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C 254	Continued From page 9 10:50am revealed: -Resident #2 was up in a geri-chair being fed by a hospice aide. -Resident #2 was unable to feed to herself. Interview with hospice aide on 05/22/19 at 10:55am revealed: -She used the hoyer lift to get Resident #2 out of bed because the resident was not able to get out of bed on her own. -Resident #2 had to be fed her meals because she was not able to feed herself. Interview with the Administrator on 05/22/19 at 11:20am revealed: -He confirmed that staff used the hoyer lift to transfer Resident #2 in and out of bed. -Resident #2 used the geri-chair and wheelchair when she was out of bed. -Resident #2 also had a nebulizer and rectal suppositories available but had not used the nebulizer or rectal suppositories since they were ordered in April 2018. -He had the LHPS initial evaluation completed for Resident #2 when she was first admitted to the facility in July 2018. -He did not know LHPS tasks were supposed to be reviewed quarterly. -No quarterly reviews had been completed for Resident #2 since she had been admitted and there had not been a re-evaluation for her new LHPS tasks. -The facility currently did not have a LHPS nurse. -The previous LHPS nurse had quit several months ago (time not specified) and was no longer available. 3. Review of Resident #3's current FL-2 dated 08/29/18 revealed diagnoses included dementia, acute renal failure, cystitis, and muscle	C 254		

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weakness.

Review of Resident #3's current care plan dated 09/5/18 revealed:
-Resident #3 was always disoriented and had significant memory loss.
-Resident #3 required a regular pureed diet with thin liquids.
-Resident #3 required extensive assistance and supervision while eating.

Review of Resident #3's physician's orders revealed there was a diet order dated 12/07/18 for a regular pureed diet with nectar-thickened liquids.

Observation of Resident #3 on 05/22/19 at various times from 11:30am to 12:00pm revealed:
-Resident #3 was fed her lunch meal that consisted of pureed chicken and spinach by the Administrator.
-The Administrator fed Resident #3 using a spoon while Resident #3 sat in an upright position at the kitchen table.
-Resident #3 drank a pineapple smoothie and took sips of water with a nectar consistency.
-Resident #3 occasionally coughed while she was being fed by the Administrator.
-The Administrator made sure Resident #3 cleared her throat and swallowed before he offered the next spoon of food.
-Resident #3 was unable to fed herself and had to be feed by the Administrator.

Interview with Administrator on 05/22/19 at 11:40am revealed:
-He found out by trial and error that Resident #3 would not open her mouth for more food if she still had food in her mouth she had not swallowed.

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C 254	Continued From page 11 -Resident #3 required feeding assistance since she was admitted at the facility. -He was not sure how long Resident #3 had been on nectar thickened liquids, but she did have some swallowing problems. -If the LHPS evaluation and reviews were not in Resident #3's record, then it had not been done. -He forgot to get a LHPS evaluation completed for Resident #3 for her feeding assistance needs. -He was responsible for making sure the LHPS initial evaluations and quarterly reviews for residents who had LHPS tasks were completed.	C 254		