STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 and Robeson County Social Services conducted a follow up survey on August 02, 2019.	{C 000}		
{C 022}	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 5 of 6 residents sampled (#1, #2, #3, #4, #6) who were physically and/or cognitively unable to evacuate the facility independently. The findings are: Review of the facility's current provisional license effective 07/22/19 revealed the facility had a license for 6 total residents, with a maximum of 3 non-ambulatory residents. Review of the daily census revealed 6 residents resided in the facility on 08/02/19.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 1 Observation on 08/02/19 at 9:45am revealed: -One staff member, a live-in personal care aide (PCA) was on duty. -Resident #1 was outside of the facility, standing on a walkway on the right side of the facility, smoking a cigarette. -Resident #6 was sitting in a chair watching television in the living room. -Resident #2 and Resident #3 were each sitting in geriatric chairs in the living room next to each other. -Resident #4 was asleep, sitting in a wheelchair in the living room beside Resident #2. Interview with the live-in PCA on 08/02/19 at 9:45am revealed Resident #5 was at a day program he attended Monday through Friday and returned to the facility daily between 2:30pm - 3:30pm. 1. Review of Resident #1's current FL-2 dated 09/8/18 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, tobacco use, schizophrenia, and dementia. -There was documentation Resident #1 was intermittently disoriented. -There was documentation Resident #1 was ambulatory. Review of Resident #1's Care Plan dated 10/19/18 revealed: -The resident required limited assistance from staff for bathing, dressing, and grooming, was independent with eating, ambulation, and transferring, and supervision with toileting. -There was documentation the resident was sometimes disoriented, forgetful and needed reminders.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 2 Observations of Resident #1 intermittently on 08/02/19 from 9:45am - 6:30pm revealed the resident was back and forth between the front porch and out on the facility grounds, the living room, and his bedroom most of the day. Interview with Resident #1 on 08/02/19 at 10:14am revealed: -The resident remembered a fire drill recently at the facility. -The resident did not remember hearing a fire alarm because the drill was for practice only. -The resident got out of the facility during the fire drill. -The resident was told by the Administrator if a fire happened to get out of the facility. Attempted follow up interview with Resident #1 on 08/02/19 at 4:10pm was unsuccessful. Observation of a fire drill conducted by facility staff on 08/02/19 at 4:18pm revealed: -The Business Office Manager (BOM) initiated a fire drill by activating a loud fire alarm that could be heard throughout the facility. -Resident #1 was in his room. -Resident #1 heard the fire alarm, immediately stopped talking to the state worker and headed outside of the front door. -The live-in personal care aide (PCA) yelled "fire" to Resident #1 and two other residents who were in their rooms as she pushed the three non-ambulatory residents out the front door of the facility. -Resident #1 was observed standing in the front doorway of the building watching the live in PCA trying to get Resident #3 out. -Resident #1 was observed shaking the hand of the worker that was conducting the fire drill	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 3 -The fire drill ended when Resident #1 and all other residents were on the facility's front porch. -All residents were evacuated to the facility's front porch in less than three minutes. Interview with the live-in PCA on 08/02/19 at 3:35pm and 4:21pm revealed: -In a "real" fire she would evacuate the residents farther away from the building. -Resident #1 did not need any prompting assistance to evacuate the facility when she was present for the fire drills. Telephone interview with Resident #1's family member on 08/02/19 at 2:32pm revealed: -She visited the resident every day to every three days. -She did not think the resident had any problems with dementia and had no difficulty following commands/direction. -The resident could not live by himself because he could not manage money, cook, pay bills, shop, and meet his medical care needs. -There were some days the resident "wakes up and says he is a millionaire". -She thought that the resident would know how to respond independently, evacuating the facility in the event of an emergency such as a fire. Interview with Supervisor in Charge/medication aide (SIC/MA) on 08/02/19 at 6:00pm revealed: -The SIC/MA had spoken with the resident's primary care provider (PCP) regarding Resident's #1's level of orientation as it related to their ability to evacuate the facility in case of a fire. -The SIC/MA explained that the provider asked him if the facility held fire drills and if so, did the resident evacuate. -The SIC/MA explained that he told the PCP Resident #1 evacuated during each drill.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 4 -The PCP could not override a diagnosis that Resident #1 had before she became the PCP. Interview with the Business Office Manager (BOM) on 08/02/19 at 6:30pm revealed: -She had no concerns that Resident #1 would not make it out of the facility safely in the event of a real fire. -Resident #1 was independent with ambulation and would be able to safely exit the facility in the event of a real fire on his own. Telephone interview with the Administrator on 08/02/19 at 5:06pm revealed: -She would have to check and see if the SIC/MA contacted the PCP to review the orientation status checked on Resident #1's current FL-2 since May 2019. -She had no concerns with Resident #1's ability to respond without prompting and get out of the facility in the event of an emergency such as a fire. -During the facility fire drills she had conducted, Resident #1 always responded and exited the facility. Attempted telephone interview with Resident #1's PCP on 08/02/19 at 12:06pm was unsuccessful. Refer to the interview with the live-in PCA on 08/02/19 at 10:26am and at 1:26pm. Refer to the review of the facility's Fire Drill Policy dated 7/12/19. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/12/19 at 1:30pm. Refer to the review of facility's "Fire Rehearsal	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 5 Schedule" documentation dated 07/18/19 at 9:48am. Refer to the telephone interview with the Fire Marshal on 08/02/19 at 3:15pm Refer to the observations on 08/02/19 at 4:47pm. Refer to the telephone interview with Administrator on 08/02/19 at 5:06pm. 2. Review of Resident #6's current FL-2 dated 10/1/18 revealed: -Diagnosis included Cognitive impairment, hypertension, traumatic brain injury, hearing deficit and benign prostatic enlargement. -The resident was constantly disoriented. -The resident was very hard of hearing. Review of Resident #6's Care Plan dated 09/28/18 revealed: -Resident #6 was independent with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal care hygiene, and transferring. -Resident #6 was receiving medications for mental illness. Observations of Resident #6 intermittently on 08/02/19 from 9:45am - 6:30pm revealed: -The resident would only speak when spoken too. -The resident was back and forth between the front porch, the living room, and his bedroom most of the day. Interview with the live-in personal care aide (PCA) on 08/02/19 at 10:26am revealed: -She knew there was a fire drill done approximately 2 weeks ago. -There was a "guy" that came to do a fire drill at	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 6	{C 022}		

the facility.
-She was not sure who the "guy" was.
-Resident #6 was present during the fire drill.
-When the fire drill was done, Resident #6 was in the living room, not in his room.
-Resident #6 had to be told during this fire drill to "come on, come on" and he never did.
-Resident #6 might not have understood to "come on".

Interview with Resident #6 on 08/02/19 at 10:12am and at 5:40pm revealed:
-The resident recalled a fire drill he was involved in at the facility.
-The fire alarm sounded, and all the residents went outside.
-The resident did not go outside because he did not hear the fire alarm.
-The resident's bedroom door was closed.
-A staff person came to the resident's room and asked him to evacuate.

Interview with the Business Office Manager (BOM) on 08/02/19 at 10:27am and at 4:40pm revealed:
-Resident #6 was hard of hearing.
-When she spoke with Resident #6, she always was face to face with him and had to "kind of holler at him" in a raised voice when she talked to him for the resident to hear her.
-Resident #6 saw his primary care provider (PCP) a few weeks ago and had his ears flushed out.
-Resident #6 told her there was no need to take him to get his ears flushed out because he could not hear anyway in one ear from an accident he had several years ago.
-He had suffered from a head injury that damaged his brain, the resident told her only a small area of his brain worked.
-She had no concerns that Resident #6 would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 7 make it out of the facility safely in the event of a real fire. Interview with a second live-in PCA on 08/02/19 at 3:35pm revealed Resident #6 would respond and exit the facility independently with the other residents without prompting during fire drills. Observation of a fire drill conducted by facility staff on 08/02/19 at 4:18pm revealed: -The BOM initiated a fire drill by activating a loud fire alarm that could be heard throughout the facility. -Resident #6 was in his room when the fire drill was initiated. -The live-in PCA yelled "fire" to Resident #6 and two other residents in the facility who were in their rooms as she pushed the three non-ambulatory residents out the front door of the facility. -Resident #6 initially did not respond to the audible fire alarm nor the illuminated blinking light indicator device that was in his bedroom on the left wall for approximately 8 seconds, had a blank stare, then responded "what is that .... I don't know, it's an alarm". -The resident slowly walked to the door and stood at the doorway for approximately 8 seconds, then slowly walked down the hallway. -While the resident was slowly walking down the hallway of the facility, he said "it's a mock fire drill". -At 4:19pm, the live-in PCA told Resident #6 "to speed up". -Resident #6 walked slowly out the facility's front door and onto the facility's front porch at 4:19pm. -The fire drill ended when Resident #6 and all other residents were on the facility's front porch. -All residents were evacuated to the facility's front porch in less than three minutes.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 8 Interview with the live-in PCA on 08/02/19 at 4:21pm revealed in a 'real" fire she would evacuate the residents farther away from the building. Second interview with Resident #6 on 08/02/19 at 4:30pm revealed: -He had trouble hearing out of his left ear, he could hear better out of his right ear. -He felt like he did not need to rush out of the house during the fire drill because he knew there was not a real fire. -He would help get the other residents out (named) if there were a real fire because they were "disabled". Interview with the Supervisor in Charge/medication aide (SIC/MA) on 08/02/19 at 6:22pm revealed: -The SIC/MA observed that Resident #6 was the first resident out of the facility during one of the drills. -He thought Resident #6 would not have any issues with getting out the facility safely in the event of a real fire. -Resident #6 would be able to hear the fire alarm, because it was next to his room door. -The SIC/MA spoke with Resident #6's PCP regarding Resident's #6's level of orientation as it related to their ability to evacuate the facility in case of a fire. -The SIC/MA explained that the provider asked him if the facility held fire drills and if so, did the resident evacuate. -The SIC/MA explained that he told the PCP Resident's #6 evacuated during each drill. -The PCP could not override a diagnosis that Resident #6 had before she became the PCP. Interview with the BOM on 08/02/19 at 6:30pm	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 9	{C 022}		

revealed:
-She had no concerns that Resident #6 would not make it out of the facility safely in the event of a real fire.
-Resident #6 was independent ambulating and would be able to safely exit the facility in the event of a real fire.
-She did observe during today's fire drill that Resident #6 stood at his door and was slow to walk out. She thought Resident #6 knew the drill was "fake" and that was why he did not rush out of the facility,

Telephone interview with the Administrator on 08/02/19 at 3:45pm revealed Resident #6 evacuated the facility each time a fire drill was conducted without prompting or assistance.

Attempted telephone interview with Resident #6's legal guardian on 08/02/19 at 3:17pm was unsuccessful.

Attempted telephone interview with Resident #6's PCP on 08/02/19 at 12:17pm was unsuccessful.

Refer to the interview with the live-in PCA on 08/02/19 at 10:26am and at 1:26pm.

Refer to the review of the facility's Fire Drill Policy dated 7/12/19.

Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/12/19 at 1:30pm.

Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/18/19 at 9:48am.

Refer to the telephone interview with the Fire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 10 Marshal on 08/02/19 at 3:15pm Refer to the observations on 08/02/19 at 4:47pm. Refer to the telephone interview with Administrator on 08/02/19 at 5:06pm. 3. Review of Resident #2's current FL-2 dated 03/07/19 on 08/02/19 at 12:53pm revealed: -Diagnosis included anemia, gastrointestinal bleed, Alzheimer's/dementia and atrial fibrillation. -There was documentation the resident was constantly disoriented and non-ambulatory. -There was documentation the resident required total care for personal care assistance. Review of Resident #2's Care Plan dated 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring. Observation of Resident #2 intermittently on 08/02/19 from 9:45am - 6:30pm revealed: -The resident was observed in a Geri-chair in the living room, and at other times lying in bed in her room. -Staff were observed transferring the resident using a mechanical lift at least twice during the day. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). -The resident was provided feeding assistance by the live-in personal care aide (PCA). Interview with a live-in PCA on 08/02/19 at 10:10am revealed: -Resident #2 was totally dependent on staff for all her needs. -Staff used a mechanical lift to transfer Resident #2.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 11 Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. Observation of a fire drill conducted by facility staff on 08/02/19 at 4:18pm revealed: -The Business Office Manager (BOM) initiated a fire drill by activating a loud fire alarm that could be heard throughout the facility. -Resident's #2 was in the living room reclined in a Geri-chair. -Resident #2 was pushed out of the front exit door and onto the front porch first by the live-in PCA at 4:18pm. -The fire drill ended when Resident #2 and all other residents were on the facility's front porch. -All residents were evacuated to the facility's front porch in less than three minutes. Interview with the live-in PCA on 08/02/19 at 4:21pm revealed: -She pushed Resident #2 onto the facility's front porch because it was only a drill. -In a "real" fire she would evacuate Resident #2 farther away from the building. Telephone interview with Resident #2's family member revealed on 08/02/19 at 3:15pm revealed: -Resident #2 was completely dependent on staff for all her personal care needs including transferring and mobility. -Resident #2 was unable to turn and reposition herself in bed. Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 12 Refer to the interview with the live-in PCA on 08/02/19 at 10:26am and at 1:26pm. Refer to the review of the facility's Fire Drill Policy dated 7/12/19. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/12/19 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/18/19 at 9:48am. Refer to the telephone interview with the Fire Marshal on 08/02/19 at 3:15pm Refer to the observations on 08/02/19 at 4:47pm. Refer to the telephone interview with Administrator on 08/02/19 at 5:06pm. 4. Review of Resident #3's current FL-2 dated 09/15/18 revealed: -Diagnoses included leg swelling/anemia, congestive heart failure, depression, failure to thrive, myocardial infarction, and syncope. -Resident #3 was non-ambulatory -There was documentation Resident #3 was intermittently disoriented. Review of Resident #3's Care Plan dated 02/21/19 revealed: -Resident #3 required extensive assistance from staff with eating, toileting, ambulation, bathing, and transfers. -Resident #3 was totally dependent upon staff for ambulation. Interview with a live-in personal care aide (PCA)	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 13 on 08/02/19 at 10:10am revealed: -Resident #3 was totally dependent on staff for all his needs but could feed himself. -Staff used a mechanical lift to transfer Resident #3. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). Interview with Resident #3 on 08/02/19 at 10:01am revealed the resident was not able to remember the last fire drill. Observation of a fire drill conducted by facility staff on 08/02/19 at 4:18pm revealed: -The Business Office Manager (BOM) initiated a fire drill by activating a loud fire alarm that could be heard throughout the facility. -Resident's #3 was in the living room reclined in a Geri-chair. -Resident #3 was pushed out of the facility's front exit door and onto the front porch by the live-in PCA at 4:19pm. -The fire drill ended when Resident #3 and all other residents were on the facility's front porch. -All residents were evacuated to the facility's front porch in less than three minutes. Interview with the live-in PCA on 08/02/19 at 4:21pm revealed: -She pushed Resident #3 onto the facility's front porch because it was only a drill. -In a "real" fire she would evacuate Resident #3 farther away from the building. Review of a court document dated 05/05/18 revealed Resident #3 was appointed a guardian of the person. Attempted telephone interview with Resident #3's guardian on 08/02/19 at 12:12pm was	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 14 unsuccessful. Attempted telephone interview with Resident #3's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful. Refer to the interview with the live-in PCA on 08/02/19 at 10:26am and at 1:26pm. Refer to the review of the facility's Fire Drill Policy dated 7/12/19. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/12/19 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/18/19 at 9:48am. Refer to the telephone interview with the Fire Marshal on 08/02/19 at 3:15pm Refer to the observations on 08/02/19 at 4:47pm. Refer to the telephone interview with Administrator on 08/02/19 at 5:06pm. 5. Review of Resident #4's current FL-2 dated 03/21/19 revealed: -Diagnoses included mental retardation, osteoarthritis, hypertension, reflex anxiety and depressive disorder. -There was documentation Resident #4 was constantly disoriented. -There was documentation Resident #4 was semi-ambulatory and used a wheelchair to ambulate. -There was documentation Resident #4 required extensive care for bathing and dressing.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 15 Review of Resident #4's Care Plan dated 12/11/18 revealed: -Resident #4 required extensive assistance with eating, ambulation, bathing, dressing, and transfers. -Resident #4 was totally dependent upon staff for toileting and grooming. Interview with a live-in personal care aide (PCA) on 08/02/19 at 10:10am revealed: -Resident #4 could feed herself but required staff assistance for all other needs. -Resident #4 could propel her wheelchair short distances. -Resident #4 used a mechanical lift for transfers and was not ambulatory. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Observation of a fire drill conducted by facility staff on 08/02/19 at 4:18pm revealed: -The Business Office Manager (BOM) initiated a fire drill by activating a loud fire alarm that could be heard throughout the facility. -Resident #4 was in the living room sitting in a wheelchair. -Resident #4 was pushed out of the front exit door and onto the facility's front porch by the live-in PCA at 4:19pm. -The fire drill ended when Resident #4 and all other residents were on the facility's front porch. -All residents were evacuated to the facility's front porch in less than three minutes.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 16 Interview with the live-in PCA on 08/02/19 at 4:21pm revealed: -She pushed Resident #4 onto the facility's front porch because it was only a drill. -In a "real" fire she would evacuate Resident #4 farther away from the building. Attempted telephone interview with Resident #4's family members on 08/02/19 at 2:31pm, 2:32pm and 3:07pm was unsuccessful. Attempted telephone interview with Resident #4's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful. Refer to the interview with the live-in PCA on 08/02/19 at 10:26am and at 1:26pm. Refer to the review of the facility's Fire Drill Policy dated 7/12/19. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/12/19 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 07/18/19 at 9:48am. Refer to the telephone interview with the Fire Marshal on 08/02/19 at 3:15pm Refer to the observations on 08/02/19 at 4:47pm. Refer to the telephone interview with Administrator on 08/02/19 at 5:06pm. Interview with the live-in personal care aide (PCA) on 08/02/19 at 10:26am and at 1:26pm revealed: -Fire drills were done by the Administrator or the	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 17	{C 022}		

Business Office Manager (BOM) every few weeks.
-When she was on duty during a fire drill, staff would yell "fire, fire" get out" but the fire alarm was "pulled" when the "guy" (she was unsure of who the person was) done the fire drill a few weeks ago.

Review of the facility's Fire Drill Policy dated 7/12/19 revealed:
-Both live-in PCA staff signatures were documented on the form.
-Both PCA's signed that they understood all procedures to perform in getting their patients out of the building.
-Office staff was on the property 24/7 to assist with getting patients out of the building.
-The BOM, the Administrator, and the Supervisor in Charge/medication aide (SIC/MA) numbers were listed on the Fire Drill Policy.

Review of facility's "Fire Rehearsal Schedule" documentation dated 07/12/19 at 7:00am revealed:
-Staff included a live-in PCA and a PCA.
-The total time for all residents to evacuate the facility was 5 minutes and 14 seconds.
-The fire drill was completed at 7:00am.
-There was documentation "See attachment" written on the form.
-Staff yelled "fire, fire".
-Staff got a resident into a wheelchair and pushed the resident out "back side door, running in hallway yelling fire, fire".
-The ambulatory residents were sitting in the living room and exited out the front door.
-Another staff got a resident out of a "hospital bed" and placed the resident in a named brand mechanical lift. (A mechanical lift is a device used to transfer individuals by placing a sling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 18	{C 022}		

under the body and connecting the sling to the mechanical lift) and pushed her out the front door.
-All residents understood as they were rushing to get out of the building when fire was around.
-The Administrator talked to the ambulatory residents and the residents clearly understood to exit the building when fire was around. The Administrator asked again, and the residents fully understood to get out in case of a fire.

Review of facility's "Fire Rehearsal Schedule" documentation dated 07/18/19 at 9:48am revealed:
-Staff included a live-in PCA and a PCA.
-The total time for all residents to evacuate the facility was 2 minutes and 32 seconds.
-Staff were yelling fire in the kitchen.
-Three non-ambulatory residents were sitting in the living room and exited out of the front door.
-Three ambulatory residents were not in the building and were at the "doctor" and a day program.
-The live-in PCA "got" the three non-ambulatory residents out of the facility one by one.

Telephone interview with the Fire Marshal on 08/02/19 at 3:15pm revealed:
-The Fire Marshal was concerned one staff person could not get all six residents out of the facility in time during an active fire when the residents were unable to ambulate on their own, were disoriented, confused, and slow moving.
-The facility should be able to get all the residents out in three minutes.
-In a facility with three non-ambulatory residents that use mechanical lifts there would need to be at least three people to get the residents out of the facility timely during a fire.
-The evacuation time increased when factors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 19	{C 022}		

such as slow moving, confused, and/or disoriented residents are factored in.
-If the facility had a sprinkler system the concern would not be as great.
-If there were other staff available in adjacent buildings it would depend on the type of fire as to whether they had enough time to reach the facility.
-The fire marshal recommended the three non-ambulatory residents to be placed closest to the exit doors; one at the front door and the other two residents at the end of the hall by the side exit.

Observations on 08/02/19 at 4:47pm revealed:
-The facility was not equipped with a sprinkler system.
-The facility was ground level with no steps at the front door, a wheelchair ramp at both exit doors on each end of the facility, and an exit door in the dining room with one step that led to concrete padding at ground level.

Telephone interview with Administrator on 08/02/19 at 5:06pm revealed:
-There had been "several" fire drills conducted since May 2019.
-She never understood the rules and regulations for non-ambulatory residents related to fire safety.
-She thought if a resident was not oriented but was ambulatory and could walk around the resident would not be considered non-ambulatory.
-To increase the residents' safety, she had moved the Supervisor In Charge/medication aide (SIC/MA) on the facility grounds and would be "so many feet away" at all times.
-The SIC/MA was also inside the facility at least four times a day; she estimated he would stay in the building at least 30-35 minutes each time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 022}	Continued From page 20 -The BOM was in and out of the building all day. -She was in the facility often every day. -To increase the residents' safety in the event of a fire, she had hired one additional staff that worked from 10:00pm to 6:00am Monday through Friday that walked back and forth from to the facility from another facility that was next door throughout the shift while the live-in staff slept. -On the weekends she and the SIC/MA walked back and forth from the other facility throughout the shift while the live-in staff slept. _____ The facility failed to assure the building was equipped and maintained to allow the residents living in the facility who had physical and cognitive deficits to evacuate independently in case of an emergency such as a fire. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on 08/02/19. The POP addendum was requested on 08/05/19.	{C 022}		
{C 191}	10A NCAC 13G .0601(d) Management and Other Staff 10A NCAC 13G .0601 Management and Other Staff (d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION Based on these findings, the previous Type B	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 21 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to have sufficient staff on duty and awake at all times to meet the personal care and supervision needs for 5 of 6 sampled residents (Resident #1, #2, #3, #4 and #6). Interview with a live in personal care aide (PCA) on 08/02/19 at 3:30pm revealed: -The facility had an audible call alarm system that was activated when the residents pulled a call string that was located at the residents' bedside. -The call alarm system's main unit hub was located in the staff live-ins' sleeping quarters. -When the call system was activated by a resident an audible alarm was activated and an indicator light illuminated. 1. Review of Resident #1's current FL-2 dated 09/8/18 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), prostate cancer, tobacco use, schizophrenia, and dementia. -There was documentation Resident #1 was intermittently disoriented. -There was documentation Resident #1 was ambulatory. Review of Resident #1's Care Plan dated 10/19/18 revealed: -The resident required limited assistance from staff for bathing, dressing, and grooming, was independent with eating, ambulation, and transferring, and supervision with toileting. -There was documentation the resident was sometimes disoriented, forgetful and needed reminders.	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 22 Interview with Resident #1 on 08/02/19 at 10:14am revealed: -The resident did not pull his call string at any time. -The resident had seen a night shift worker in the facility. -The night shift worker had not provided assistance to the resident. Interview with a live in personal care aide (PCA) on 08/02/19 at 3:30pm revealed Resident #1 was independent with his personal care needs and could pull the call string for staff assistance if he needed help. Interview with the Business Office Manager (BOM) on 08/02/19 3:50pm revealed Resident #1 was independent and would pull the call string if he needed help. Telephone interview with Resident #1's family member on 08/02/19 at 2:52pm revealed; -As far she knew, the resident was independent with his personal care and only needed help with shaving due to Parkinson's disease. -Resident #1 told her that there was additional staff in the facility "now" at night while the live in staff slept. Attempted telephone interview with Resident #1's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful. Refer to the interview with the live in PCA on 08/02/19 at 10:00am. Refer to the interview with a second live in PCA on 08/02/19 at 3:30pm. Refer to the interview with the BOM on 08/02/19	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 23 3:50pm. Refer to the interview with previous third shift PCA on 08/02/19 at 4:30pm. Refer to the interview with Supervisor in Charge/medication aide (SIC/MA) on 08/02/19 at 6:05pm. Refer to the telephone interview with the Administrator on 08/02/19 at 3:45pm and 5:06pm. 2. Review of Resident #6's current FL-2 dated 10/1/18 revealed: -Diagnoses included cognitive impairment, hypertension, traumatic brain injury and hearing deficit. -There was documentation the resident was constantly disoriented. -There was documentation the resident was very hard of hearing. Review of Resident #6's Care Plan dated 09/28/18 revealed: -Resident #6 was independent with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal care hygiene, and transferring. -Resident #6 was receiving medications for mental illness. Observations of Resident #6 intermittently on 08/02/19 from 9:45am - 6:30pm revealed: -The resident would only speak when spoken too. -The resident was back and forth between the front porch, the living room, and his bedroom most of the day. Interview with a live-in personal care aide (PCA) on 08/02/19 at 10:26am revealed:	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 24 -Resident #6 "always" told her he was not sleeping at night but when she went to get the resident up for breakfast he would be sleeping. -Resident #6 was independent with his personal care needs. Interview with a second live in PCA on 08/02/19 at 3:30pm revealed Resident #6 was independent with his personal care needs and could pull the call string for staff assistance if he needed help. Interview with Resident #6 on 08/02/19 at 10:20am revealed: -He saw the awake staff come in at 10:00pm. -He did not know how long the awake staff worker stayed at night. -He went into his room at 10:00pm and did not come out until the next morning. Interview with the Business Office Manager (BOM) on 08/02/19 3:50pm revealed Resident's #6 was independent and would pull the call string if he needed help. Attempted telephone interview with Resident #6's legal guardian on 08/02/19 at 3:17pm was unsuccessful. Attempted telephone interview with Resident #6's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful. Refer to the interview with the live in PCA on 08/02/19 at 10:00am. Refer to the interview with a second live in PCA on 08/02/19 at 3:30pm. Refer to the interview with the BOM on 08/02/19 3:50pm.	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 25 Refer to the interview with the previous third shift PCA on 08/02/19 at 4:30pm. Refer to the interview with Supervisor in Charge/medication aide (SIC/MA) on 08/02/19 at 6:05pm. Refer to the telephone interview with the Administrator on 08/02/19 at 3:45pm and 5:06pm. 3. Review of Resident #2's current FL-2 dated 03/07/19 revealed: -Diagnoses included anemia, gastrointestinal bleed, Alzheimer's/dementia and atrial fibrillation. -There was documentation the resident was constantly disoriented and non-ambulatory. -There was documentation the resident required total care for personal care assistance. Review of Resident #2's Care Plan dated 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring. Observation of Resident #2 intermittently on 08/02/19 from 9:45am - 6:30pm revealed: -The resident was observed in a Geri-chair in the living room, and at other times lying in bed in her room. -Staff were observed transferring the resident using a mechanical lift at least twice during the day. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). -The resident was provided feeding assistance by the live-in personal care aide (PCA). Interview with a live-in PCA on 08/02/19 at 10:10am revealed:	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 26 -Resident #2 was totally dependent on staff for all her needs. -Staff used a mechanical lift to transfer Resident #2. Interview with a second live in PCA on 08/02/19 at 3:30pm revealed: -Resident #2 was physically and mentally unable to pull the call string for staff assistance at night. -Resident #2 was totally dependent on staff for all her needs. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. Telephone interview with Resident #2's family member on 08/02/19 at 3:15pm revealed: -Resident #2 was completely dependent upon staff for all her personal care needs. -Resident #2 was unable to turn and reposition herself in bed. Interview with the Business Office Manager (BOM) on 08/02/19 6:26pm revealed: -Resident #2 could not use the call string for staff assistance. -Resident #2 could not yell for staff if she needed assistance. -She could understand why there was a safety concern because Resident #2 could not signal staff for help and there was not awake staff in the facility the entire time between 10:00pm to 6:00am when the live-in staff were asleep. Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful. Refer to the interview with the live in PCA on	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 27 08/02/19 at 10:00am. Refer to the interview with a second live in PCA on 08/02/19 at 3:30pm. Refer to the interview with the BOM on 08/02/19 3:50pm. Refer to the interview with the previous third shift PCA on 08/02/19 at 4:30pm. Refer to the interview with Supervisor in Charge/medication aide (SIC/MA) on 08/02/19 at 6:05pm. Refer to the telephone interview with the Administrator on 08/02/19 at 3:45pm and 5:06pm. 4. Review of Resident #3's current FL-2 dated 09/15/18 revealed: -Diagnoses included leg swelling/anemia, congestive heart failure, depression, failure to thrive, myocardial infarction, and syncope. -Resident #3 was non-ambulatory -There was documentation Resident #3 was intermittently disoriented. Review of Resident #3's Care Plan dated 02/21/19 revealed: -Resident #3 required extensive assistance from staff with eating, toileting, ambulation, bathing, and transfers. -Resident #3 was totally dependent upon staff for ambulation. Interview with a live-in personal care aide (PCA) on 08/02/19 at 10:10am revealed: -Resident #3 was totally dependent on staff for all his needs but could feed himself. -Staff used a mechanical lift to transfer Resident	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 28 #3. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). Interview with a second live in PCA on 08/02/19 at 3:30pm revealed Resident #3 was able to pull his call string for staff assistance and had pulled the call string for staff before. Interview with Resident #3 on 08/02/19 at 10:00am revealed: -There was a third shift worker that recently started at the facility. -The night worker helped turn him at night if he needed it. -He was able to reach his call string if he needed it. Interview with Resident #3's hospice personal care aide (PCA) on 08/02/19 at 11:38am revealed: -There was always a live in PCA in the facility when the hospice PCA came to see Resident #3. -She was unaware if there was awake staff in the facility at night. Interview with the Business Office Manager (BOM) on 08/02/19 3:50pm and 6:26pm revealed: -She thought Resident #3 would not pull the call string if he needed assistance, but would probably yell out if he needed assistance. -She could understand why there was a safety concern because Resident #3 might not pull his call string for help and there was not awake staff in the facility the entire time between 10:00pm to 6:00am when the live-in staff were asleep. Attempted telephone interview with Resident #3's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful.	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 29 Refer to the interview with the live in PCA on 08/02/19 at 10:00am. Refer to the interview with a second live in PCA on 08/02/19 at 3:30pm. Refer to the interview with the BOM on 08/02/19 3:50pm. Refer to the interview with previous third shift PCA on 08/02/19 at 4:30pm. Refer to the interview with Supervisor in Charge/medication aide (SIC/MA) on 08/02/19 at 6:05pm. Refer to the telephone interview with the Administrator on 08/02/19 at 3:45pm and 5:06pm. 5. Review of Resident #4's current FL-2 dated 03/21/19 revealed: -Diagnoses included mental retardation, osteoarthritis, hypertension, depressive disorder, other and unspecified hyperlipidemia, esophagitis, and reflex anxiety. -There was documentation Resident #4 was constantly disoriented. -There was documentation Resident #4 was semi-ambulatory and used a wheelchair to ambulate. -There was documentation Resident #4 required extensive care for bathing and dressing. Review of Resident #4's Care Plan dated 12/11/18 revealed: -Resident #4 required extensive assistance with eating, ambulation, bathing, dressing, and transfers. -Resident #4 was totally dependent upon staff for	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 30 toileting and grooming. Interview with a live-in personal care aide (PCA) on 08/02/19 at 10:10am revealed: -Resident #4 could feed herself but required staff assistance for all other needs. -Resident #4 could propel her wheelchair short distances. -Resident #4 used a mechanical lift for transfers and was not ambulatory. (A mechanical lift is a device used to transfer individuals by placing a sling under the body and connecting the sling to the mechanical lift). Interview with a second live in PCA on 08/02/19 at 3:30pm revealed: -Resident #4 was dependent with all personal care needs. -Resident #4 was unable to comprehend how to use the call string for staff assistance. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. Interview with the Business Office Manager (BOM) on 08/02/19 6:26pm revealed: -Resident #4 could not pull the call string for staff assistance. -Resident #4 could verbally call for help, however, she did not think staff would be able to hear Resident #4 since the live in quarters were on one end of the facility and Resident #4's bedroom was on the other end of the facility. -She could understand why there was a safety concern because Resident #4 could not signal for help and there was not awake staff in the facility the entire time between 10:00pm to 6:00am when the live-in staff were asleep.	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 31 Attempted telephone interview with Resident #4's family members on 08/02/19 at 2:31pm, 2:32pm and 3:07pm was unsuccessful. Attempted telephone interview with Resident #4's primary care provider (PCP) on 08/02/19 at 12:17pm was unsuccessful. Refer to the interview with the live in PCA on 08/02/19 at 10:00am. Refer to the interview with a second live in PCA on 08/02/19 at 3:30pm. Refer to the interview with the BOM on 08/02/19 3:50pm. Refer to the interview with previous third shift PCA on 08/02/19 at 4:30pm. Refer to the interview with Supervisor in Charge/medication aide (SIC/MA) on 08/02/19 at 6:05pm. Refer to the telephone interview with the Administrator on 08/02/19 at 3:45pm and 5:06pm. _____ Interview with the live in personal care aide (PCA) on 08/02/19 at 10:00am revealed: -Her working hours were from 6:00am until 10:00pm. -She slept in the staff live-in quarters which was located beside the residents' living room at the facility. -Night staff started coming in to work at the facility while she slept from 10:00pm until 6:00am every night since the first part of June 2019. -She was not sure what tasks night staff done because she was "off the clock".	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 32 Interview with a second live in PCA on 08/02/19 at 3:30pm revealed: -She was the only staff person on duty from 6:00am to 10:00pm. -She slept in the facility during her shifts from 10:00pm to 6:00am. -A night staff started in June 2019 from 10:00pm to 6:00am but did not stay in the facility the whole night. -She still got up at night when she was "off work" to "check on her people" because she was used to doing that. -The Administrator and the Supervisor In Charge/medication aide (SIC/MA) came in and out at night from 10:00pm to 6:00am on the weekends. -She was unsure how long the Administrator and the SIC/MA stayed because she shut her door at night. -Sometimes when she got up at night another staff would be in the house and at other times they were not. Interview with the Business Office Manager (BOM) on 08/02/19 3:50pm revealed: -The facility had a night shift staff person while the live-in staff slept. -The SIC/MA and the Administrator covered the third shift from 10:00pm-6:00am on Saturdays and Sundays by taking turns covering the weekends. -Monday through Friday the third shift was covered by the "third shift worker" from 10:00pm to 6:00am. -The SIC/MA and the Administrator come in every other hour to check on the residents. -She had hired a full-time "third shift worker" that had started to work Sunday-Saturday on 08/02/19, 10:00pm to 6:00am.	{C 191}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 33	{C 191}		

-The current "third shift worker" was not a PCA.
-The "third shift worker" checked on the residents to make sure they were in bed and not in distress.
-She did not know how often the Administrator and SIC/MA made rounds.
- "All I know was they came through".
-The current "third shift worker" begun work on 07/23/19.
-The "third shift worker " begun working seven days a week this weekend.
- "Check-ups" on weekends were better than not having a night shift at all.

Interview with the previous third shift PCA on 08/02/19 at 4:30pm revealed:
-She begun work at the facility the end of May 2019.
-She was initially hired to work night shift for an adjacent facility.
-She was later told she had to work both facilities.
-She worked Monday through Friday from 10:00pm-6:00am.
-She did not stay in the facility her entire shift.
-She worked in two different buildings during her shift.
-She would walk to the facility every hour and spend "not even" five minutes in the facility each visit.
-She would go to each residents' room and looked in their room to make sure the residents were okay and breathing.
-She had no idea who covered third shift on the weekends.
-She never provided care to the residents.
-She never worked on the weekends.
-Her last day of employment was 07/19/19.

Interview with SIC/MA on 08/02/19 at 6:05pm revealed:
-He and the Administrator took turns on Saturday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 34	{C 191}		

and Sundays from 10:00pm to 6:00am to check on the residents in the facility.
-The SIC/MA would "float" in periodically at night when the night shift workers did not come in.
-He would spend an hour in the facility checking on the residents to make sure they were safe in their rooms.
-He had no concerns with there being only one live in PCA in the facility at night because they had a "third shift worker".
-There was always staff in the facility to supervise and monitor the residents.
-He was not aware that the facility needed awake staff at all times.

Telephone interview with the Administrator on 08/02/19 at 3:45pm and 5:06pm revealed:
-She hired a third shift PCA on 05/31/19 that quit in July 2019.
-She hired a new "third shift worker" the same day the previous worker quit.
-The new "third shift worker" was scheduled to work Sunday through Saturday, from 10:00pm to 6:00pm.
-The "third shift worker" worked two buildings each night.
-The "third shift worker" would walk from one building to the other throughout the night.
-She or the SIC/MA would check the facility every other hour Saturday and Sunday.
-She or the SIC/MA would spend about an hour in the facility checking the residents.
-She, the BOM, and the SIC/MA checked on the residents' in the facility three to four times during the day.
-They spent at least thirty minutes in the facility during their daily checks.
-There was always staff in the facility to supervise and monitor residents.
-She was unaware she could not have "third shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 191}	Continued From page 35 worker" monitor two buildings during their shift. -The Administrator was not aware that the "third shift worker" needed to be in the building continuously. The facility failed to have awake staff on duty and awake at all times to meet the supervision and personal care needs for 5 of 6 sampled residents assessed as intermittently and/or disoriented. The facility's failure was detrimental to health, safety, and welfare of the residents and constitutes a Type B Violation. A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on 08/02/19. A POP addendums was requested on 08/05/19.	{C 191}		
{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 observations, interviews, and record reviews, 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 management and other staff and design and construction. 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
	FCL078079	A. BUILDING: _____ B. WING _____	R 08/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIAL'S FAMILY CARE HOME #10	70 CARE DRIVE PEMBROKE, NC 28372

(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 36 1. Based on observations, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 5 of 6 residents sampled (#1, #2, #3, #4, #6) who were physically and/or cognitively unable to evacuate the facility independently. [Refer to Tag 0022 10A NCAC .0302(b) Design and Construction (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to have sufficient staff on duty and awake at all times to meet the personal care and supervision needs for 5 of 6 sampled residents (Resident #1, #2, #3, #4 and #6). [Refer to Tag 0191 10A NCAC 13G .0601(d) Management and Other Staff (Type B Violation)].	{C 912}		