STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 and follow up survey from August 20, 2019 - August 21, 2019.	C 000		
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: Based on observations, interviews, and record reviews, the facility failed to have sufficient staff on duty and awake at all times to meet the care and supervision needs for 1 of 1 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 05/16/19 revealed: -Diagnoses included schizophrenia paranoid type, bronchial asthma, obesity and gastroesophageal reflux disease. -There was documentation the resident was verbally abusive. -There was documentation the resident was ambulatory. -There was no documentation for the orientation status of the resident. Review of Resident #3's Assessment and Care Plan dated 02/28/19 revealed: -There was documentation the resident was abusive and resisted care. -There was documentation the resident	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 1 "continued" to display and verbalize delusional thoughts daily, had to be told, prompted, and encouraged to take a bath and "acts like" she could not perform her personal hygiene, and grooming at all. -There was documentation the resident "had behavioral problems" when the resident was out in the community. The resident would refuse to get back into the van and told staff she was waiting for a friend to come and get her; staff had to make her get in the van; and the resident was getting worse with that. -There was documentation the resident was oriented and sometimes disoriented. -There was documentation the resident was forgetful and needed reminders. -The resident was independent with eating, toileting, ambulation, bathing, dressing, grooming and transferring. Review of a visit encounter with Resident #3's primary care provider (PCP) dated 10/30/18 revealed: -Resident #3 was seen for a check-up. -The resident's "caregiver" wanted to get some referrals made because they had noticed that her dementia seemed to be getting worse and they wanted the resident to be checked by a neurologist. -The resident was currently on Aricept, but they thought it was not working. (Aricept is a medication used to treat confusion). -There was documentation in the physical exam section the resident was oriented to person, place, time and situation and had a flat affect. -There was documentation in the assessment and plan section "dementia", continue Aricept and a neurology consult would be made. Review of a clinic visit with a Neurologist for	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 2	C 191		

Resident #3 dated 01/24/19 revealed:
-The resident was seen for an evaluation of memory impairment.
-The resident had lived in a "group home" for more than 10 years.
-The resident had multiple psychiatric issues including schizophrenia and depression.
-The resident could not tell the year but apart from her Mini-Mental status examination was "pretty good" 25/30. (An exam performed to measure a person's cognitive function and used to screen for cognitive loss).
-The resident had some memory impairment per the caretaker who came to the visit with the resident.
-In the impression section of the form there was documentation that included schizophrenia, medications could cause memory impairment, difficulty focusing and concentrating. The caregiver reported that the resident "gets confused" off and on, or "talks out of her head" and hears things. "Sounded" more like symptoms of schizophrenia rather than dementia.

Interview with the Supervisor-in-Charge (SIC) on 08/20/19 at 7:30am and 8:30am revealed:
-She was the only staff in the home.
-She permanently lived in the facility and had her own bedroom.
-She was "off work" between 11:00pm-12:00am.
-She woke up around 3:00am to check on the residents.
-She woke up at 6:30am daily and at 7:00am she would serve the residents breakfast.
-Resident #3 was "in and out", "gets confused, turned around and mixed up at times".
-Resident #3 "forgets where she is" at times.
-She had to prompt Resident #3 by reminding and reviewing with the resident where she was. This occurred in the facility as well as in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 3	C 191		

community when they were on group outings.
-Resident #3 would forget she was in the facility.
-At times, Resident #3 would get dressed up and wait at the facility's front door for a ride.
-The last time this happened was on Saturday, 08/17/19. She had to re-direct Resident #3 that it was night time and to return to her room to get her sleep clothes on but, sometimes the resident would argue with her about that.
-She had a "hard time" getting Resident #3 back into the van when they were on outings.
-All exit doors (kitchen and front of house) and 1 window (bathroom) were wired with an alarm.
-The facility had an audible call alarm system that was activated if the residents opened any of the exit doors or window.
-The call system's main unit hub was located outside the SIC's live-in bedroom.
-Resident #3 never tried to go outside at night when she was asleep.
-The alarm was set by hand with a code by the SIC at 8:30pm and was disarmed by the SIC at 6:30am.
-If the alarm sounded the call system would place a call to the facility owner's house, and it would also alarm to the local police department.
-There was no call bell system for the residents within the facility.

Observation in Resident #3's room on 08/20/19 at 10:47am revealed there was an incontinent linen saver on the floor with 2 small yellow/brown colored stains located beside the resident's bed.

Interview with Resident #3 on 08/20/19 at 10:47am revealed:
-She had lived at the facility for 2 years.
-There were times during the night her mother came to the facility but did not visit and waited until she was asleep.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 4 -She knew her mother came to the facility at night because someone told her. -She thought her mother placed the incontinent linen saver on the floor. -There was no staff in the facility at night, then stated staff stayed in their room "I think". -The resident did not require staff assistance to get up at night to use the bathroom. A third interview with the SIC on 08/20/19 at 10:58am revealed: -No family members visited Resident #3 except one family member this past Saturday (08/17/19) which was the first time the resident had a visitor since she had worked at the facility. -Resident #3 had been urinating on the floor in her room which was becoming worse and the resident "swears" it was someone else doing it. -She and the Administrator had recently discussed having Resident #3 "moved". Interview with the SIC on 8/21/19 at 8:28am revealed: -Resident #3 had confusion in her conversation. -There had been a progression of Resident #3's confusion with "conversation". -Resident #3's confusion had started a few weeks ago and it mostly happened at night. -The SIC would assist Resident #3 with her personal care. She would make sure Resident #3 had stand by assistance without providing any hands-on assistance. -Resident #3 was able to dress herself and if Resident #3 had an incontinent episode she was independently able to complete her perineal care. -Resident #3 had no falls since her admission to the facility that she was aware of. -During her appointment with her PCP, the SIC had informed him Resident #3 was having memory lapses and required prompting to get in	C 191		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 5	C 191		

the facility's van when the residents were attending an outing outside of the facility.
- Resident #3 "Doesn't ever forget where she is. She was aware of her surroundings; not in conversation though."
-There was not a requirement for prompting to remind Resident #3 of her location when she was within the facility.
-The SIC would have to tell her 2-3 times to do something while in the facility.
-Resident #3's confusion occurred about four times a week.
-She did not think Resident #3 required awake staff.
-Resident #3 never came down the hallway at night and the kitchen was locked at night.

Telephone interview with Resident #3's licensed professional counselor on 08/20/19 at 11:50am revealed:
-The resident had schizophrenia and schizoaffective disorder.
-The resident had some delusions, but not to the point that she would be a harm to herself or anyone else.
-The resident was more coherent than she was 6 years ago.
-Resident #3 had behaviors and would need redirection with the behavior only.
-She was under the impression when staff were clocked off, staff were still in the home, there were 5 other residents in the home and could knock on the staff's door if the residents needed the staff.

Telephone interview with Resident #3's PCP on 08/21/19 at 11:20am revealed:
-It was difficult to say if Resident #3 was disoriented due to her medical diagnosis of schizophrenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 6 -Resident #3 went to a neurologist on 01/24/19. -From the neurologist notes dated 01/24/19, he read the diagnosis of dementia without behavioral disturbances. -Resident #3 also had a medical history of depression and her medications could cause confusion. -The PCP thought there was a possible need for 24 hour awake staff seven days a week for Resident #3 and would be "worthwhile" for the resident's safety due to the resident's confusion. - "I would need to check her out". Telephone interview with the Administrator on 08/21/19 at 11 04:15pm revealed: -She was responsible for the total operation of the facility. -She stayed with Resident #3 the night of 08/20/19 from 10:00pm-06:00am to determine the need for awake staff. -From her observations, Resident #3 woke two times during the night to go to the bathroom without any assistance and had an uneventful night. -She disagreed with the requirement for awake staff for Resident #3.	C 191		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 330	Continued From page 7 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to an inhaler. The findings are: Review of Resident #3's current FL-2 dated 05/16/19 revealed: -Diagnoses included schizophrenia paranoid type, bronchial asthma, obesity and gastroesophageal reflux disease. -There was an order for Anoro Ellipta 62.5-25mcg inhale one puff daily. (Anoro Ellipta is an inhaled medication used for the maintenance treatment of airflow obstruction). Review of Resident #3's June 2019 medication administration record (MAR) revealed: -There was a computer generated entry for Anoro Ellipta 62.5-25mcg inhale one puff every day with a scheduled administration time of 8:00am. -Anoro Ellipta 62.5-25mcg was documented as administered from 06/01/19 - 06/30/19 at 8:00am. Review of Resident #3's July 2019 MAR revealed: -There was a computer generated entry for Anoro Ellipta 62.5-25mcg inhale one puff every day with a scheduled administration time of 8:00am. -Anoro Ellipta 62.5-25mcg was documented as administered from 07/01/19 - 07/31/19 at 8:00am. Review of Resident #3's August 2019 MAR revealed: -There was a computer generated entry for Anoro Ellipta 62.5-25mcg inhale one puff every day with a scheduled administration time of 8:00am. -There was no documentation Anoro Ellipta	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 330	Continued From page 8 62.5-25mcg was administered from 08/01/19 - 08/20/19 at 8:00am. Telephone interview with a representative from the contracted pharmacy on 08/21/19 at 10:05am revealed: -Anoro Ellipta 62.5-25mcg was last dispensed on 10/04/18 with a quantity of 60 total doses for Resident #3. -The pharmacy sent Resident #3's Anoro Ellipta to the facility by overnight mail which meant the medication would have been available at the facility on 10/05/18. Observation of Resident #3's medications on hand on 08/21/19 at 9:20am revealed Anoro Ellipta was available with a pharmacy dispensing label dated 10/01/18 and an unreadable quantity dispensed due to an ink smudge over a section of the label. -The dose counter on the inhaler device displayed 22 doses remaining. -There was an unreadable handwritten entry below "Tray opened" on the inhaler device. Interview with the Supervisor-in-Charge (SIC) on 08/21/19 at 9:23am revealed: -She administered the residents' ordered medications every day at the facility. -Anoro Ellipta was not given daily in August 2019 to Resident #3. -She thought it was an as needed (prn) medication, "it was my oversight". -She had documented she administered Resident #3's Anoro Ellipta on the June and July 2019 MAR, however, that was an error because she always thought the medication was ordered on an as needed basis. -The SIC had not made the primary care physician (PCP) aware Resident #3 had not	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054066	A. BUILDING: _____ B. WING _____	R 08/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S FAMILY CARE HOME	306 E LENOIR STREET KINSTON, NC 28501

(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 330	Continued From page 9	C 330		

received her Anoro Ellipta daily.
-The MARs were taken by the SIC to the Administrator's office on a monthly basis.
-The MARs from the previous two months were maintained in the resident's record onsite at the facility.
-She was not sure if the Administrator reviewed the residents' MARs when delivered to the office.
-She compared the MARs with the resident's current physician's orders.

Interview with Resident #3's PCP on 08/21/19 at 11:20am revealed:
-He was not aware that Resident #3 was not receiving her Anoro Ellipta daily.
-It was not critical that Resident #3 was not receiving her Anoro Ellipta.
-He felt the medication should be used if Resident #3 was symptomatic, for example, more winded when walking around.

Telephone interview with Resident #3 on 08/21/19 at 3:30pm revealed she had not had any shortness of breath that she knew of, "not yet anyway".

Telephone interview with the Administrator on 08/21/19 at 4:15pm revealed:
-She was not aware Resident #3 was not receiving her Anoro Ellipta daily.
-She thought this matter should have been caught by the contracted pharmacy when dispensing the medication to the facility.