

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL078079

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING:

ADULT CARE LICENSURE SECTION
RALEIGH

PRINTED: 08/19/2019
FORM APPROVED

(X3) DATE SURVEY
COMPLETED

08/31/2019

NAME OF PROVIDER OR SUPPLIER

DIAL'S FAMILY CARE HOME #10

STREET ADDRESS, CITY, STATE, ZIP CODE

70 CARE DRIVE

PENNSBORO, NC 28373

(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 ITS APPROPRIATE
DEFICIENCY)

(X5)
COMPLETE
DATE

C-000 Initial Comments

C-000

The Adult Care Licensure Section and Robeson
County Department of Social Services conducted
an annual survey from May 29, 2019 - May 31,
2019.

C-022 10A NCAC 13G .0302 (b) Design And
Construction

C-022

10A NCAC 13G .0302 Design And Construction

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:
TYPE B VIOLATION

Based on observations, interviews, and record
reviews, the facility failed to assure the building
was equipped and maintained for 5 of 8 residents
examples (#1, #2, #3, #4, #5) who were physically
situated cognitively unable to evacuate the facility
independently.

The findings are:

Review of the facility's current license effective
01/01/19 revealed the facility was licensed for 8
total residents, with a maximum of 3
non-ambulatory residents.

Review of the daily census revealed 5 residents
resided in the facility on 05/29/2019.

Observation on 05/29/19 at 9:45am revealed:
-One staff member, a live-in personal care aide

upon observations, 5/31/19
Facility has (3) non
and (3) amb. 3 residents
are able to walk and
3 unable.

RECEIVED

SEP 10 2019

ADULT CARE LICENSURE SECTION
RALEIGH

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER'S SIGNATURE

TITLE

DATE

STATE FORM

[Signature]

[Signature]

June 26, 2019

POC Reviewed, Not Accepted

A follow up survey was
conducted on August 02, 2019.
This plan of correction has
been reviewed/acknowledged

[Signature] 10/11/19

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NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 (PCA) was on duty. -Resident #1 was standing outside at the entrance of the facility smoking a cigarette. -Resident #6 was sitting in a chair outside at the entrance of the facility. -Resident #2 was sitting in a geriatric chair in the living room next to Resident #4. -Resident #3 was sitting in a geriatric chair in the living room watching television. -Resident #4 was sitting in a geriatric chair watching television, in between Resident #2 and #4. 1. Review of Resident #3's current FL-2 dated 09/15/18 revealed: -Diagnoses of 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 2/21/19 revealed: -Resident #3 required extensive assistance from staff with eating, toileting, ambulation, bathing, and transfers. -Resident #3 was totally dependent upon staff for ambulation. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 03/18/19 revealed the resident's LHPS tasks included assistance with ambulation and mechanical lift transfers. (A Mechanical lift is a device used to transfer individual's by placing a sling under the body and connecting the sling to the mechanical lift). Interview with a live-in personal care aide (PCA)	C 022		

5/31/19

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C 022	Continued From page 2 on 05/29/19 at 10:03am revealed: -Resident #3 could not walk. -Resident #3 required extensive assistance from staff with bathing, dressing, and toileting. -Resident #3 required a one-person transfer using a mechanical lift. (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 05/29/19 at 11:00am revealed: -Resident #3 had lived at the facility for a long time. -He liked living at the facility and watching television. Review of a court document dated 05/05/18 revealed Resident #3 was appointed a guardian of the person Observations of Resident #3 intermittently on 05/29/19 from 9:45am - 11:33am revealed: -The resident was talkative but could not stay focused in conversation and would divert to different off subject conversations. -The resident asked the same question repeatedly. -At 11:33am on 05/29/19 the resident was checked out of the facility by his guardian who transferred the resident via personal vehicle and returned the resident to the facility on 05/30/19. Interview with Resident #3's hospice PCA on 05/30/19 at 9:21am revealed the hospice PCA transferred Resident #3 with a mechanical lift with no assistance. Interview with Resident #3's hospice nurse on 05/31/19 at 11:02am revealed:	C 022			

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C 022	Continued From page 3 -The hospice nurse had worked with the resident quite a bit since being under hospice care. -The patient would need assistance in order to get out of the building in case of an emergency. Interview with a second live-in PCA on 05/31/19 at 10:58am revealed she used the mechanical lift with no assistance to transfer Resident #3. Attempted telephone interview with Resident #3's guardian was unsuccessful on 05/31/19 at 9:05am. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. 2. Review of Resident #1's current FL-2 dated	C 022		

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PEMBROKE, NC 28372**

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C 022	Continued From page 4 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 Resident #1 required limited assistance from staff for bathing, dressing, and grooming, was independent with eating, ambulation, and transferring, and supervision with toileting. Interview with Resident #1 on 05/31/19 at 11:08am revealed: -He would get all the residents out of the facility including himself if there was a fire. -He had been through a fire drill at the facility. -The staff get the "senior citizens" out of the facility first during a fire drill. -The fire alarm sounding meant that there is a fire in the "house". Telephone interview with a family member of Resident #1 on 05/31/19 at 10:22am revealed: -She visits the resident every other day. -It depended on Resident #1's "state of mind" in regard to if he would know to exit the facility during a fire. Interview with Resident #1's primary care provider (PCP) on 05/30/19 at 5:06pm revealed she would be concerned that Resident #1 would not know when to return back into the building if a fire were to occur. Refer to the review of facility's "Fire Rehearsal	C 022		

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C 022	Continued From page 5 Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in personal care aide (PCA) on 05/31/19 at 2:22pm Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. 3. 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	C 022		

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C 022	Continued From page 6 12/11/18 revealed: -Resident #4 requires extensive assistance with eating, ambulation, bathing, dressing, and transfers. -Resident #4 was totally dependent upon staff for toileting and grooming. Observation of Resident #4 on 05/29/19 - 5/31/19 at varying times revealed: -The resident ambulated in a wheelchair which she propelled on her own. -Staff used a mechanical lift to assist Resident #4 with getting into and out of her bed. (A mechanical lift is a device used to transfer individuals by placing a sling under the body connecting the sling to the mechanical lift). Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am revealed: -Resident #4 used a mechanical lift for transfers and was not ambulatory but could propel her wheelchair in her bedroom. -Resident #4 was dependent on staff for her personal care needs but could independently eat meals without staff assistance. Telephone interview with Resident #4's guardian on 05/31/19 at 9:06am revealed: -The guardian visited two times a month. -Resident #4 might be able to get herself out of the facility in the event of a fire if she was in her wheelchair. -She believed the Resident #4 knew what the fire alarm was for. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. Refer to the review of facility's "Fire Rehearsal	C 022		

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C 022	Continued From page 7 Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the confidential staff interview Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. 4. Review of Resident #6's current FL-2 dated 10/01/18 revealed: -Diagnoses included cognitive impairment, hypertension, traumatic brain injury and hearing deficit. -There was documentation Resident #6 was ambulatory. -There was documentation Resident #6 was constantly disoriented. -There was documentation Resident #6 was very hard of hearing. Review of Resident #6's Care Plan dated 08/28/18 revealed: -Resident #6 was independent with eating.	C 022		

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PEMBROKE, NC 28372**

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C 022	Continued From page 8 toileting, ambulation/locomotion, bathing, dressing, grooming/personal care hygiene, and transferring. -Resident #6 was receiving medications for mental illness. Interview with Resident #6 on 5/31/19 at 11:02am revealed: -If there was a fire in the facility he would first look for a fire extinguisher. -He would get everyone out of the facility. -It would be "up to" him to get all the residents out of the facility. -He would tell the worker about the fire. -He had not been through a fire drill at the facility. Interview with a live-in personal care aide (PCA) on 05/30/19 at 3:12pm revealed Resident #6 had "short term memory loss". Interview with Resident #6's guardian on 5/31/19 at 9:56am revealed: -Resident #6 would know to evacuate the facility in case of a fire. -The guardian was unsure if Resident #6 would know when it was safe to re-enter the facility. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm.	C 022		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078078	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED: 05/31/2019
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C 022	Continued From page 9	C 022		
	Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. 5. Review of Resident #2's current FL-2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesophageal reflux disease. -There was documentation the resident was constantly disoriented. -There was documentation the resident required total care for personal care assistance from staff. 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. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am revealed Resident #2 used a mechanical lift for transfers, was not able to ambulate and was totally dependent on staff for all of her needs. (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). A second interview with the live-in PCA on			

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C 022	Continued From page 10 05/31/19 at 2:22pm revealed: -Resident #2 was completely dependent on staff to get her out of the facility in the event of a fire. -If a fire occurred while Resident #2 was in bed, she would drag the bed mattress with the resident on it out of the facility but Resident #2 was "heavy". Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm. Refer to the interview with Administrator on 05/31/19 at 3:06pm. Review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm	C 022		

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C 022	Continued From page 11 revealed: -Staff included a live-in personal care aide (PCA) and the Business Office Manager (BOM). -The total time for all residents to evacuate the facility was 5 minutes. -The fire drill was completed at 1:35pm. -The live-in PCA "pushed out Resident #2 first, then Resident #4 while the live-in PCA was telling everyone else to go out the front door, then the live-in PCA got Resident #3 out of the "house" Review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54" revealed: -Staff included a live-in PCA and the BOM. -The total time for all residents to evacuate the facility was 9 minutes. -The residents were in the living room during the drill. -The live-in PCA told the residents to evacuate. -The live-in PCA "got" the three non-ambulatory residents out of the facility one by one. Interview with the BOM on 05/30/19 at 5:00pm revealed: -She was responsible for performing unannounced fire drills for the facility every 3 months. -During the fire drills, she pulled the fire alarm and observed the reactions of the live-in PCAs, resident reactions and timed how long it took to evacuate the residents. -Staff had been trained in the event of a fire to always evacuate the residents at an exit away from the fire. -If Resident #2 was in the bed, the live-in PCAs had been instructed to always get her out first followed by the other two residents (Resident #3 and Resident #4) -Staff had been instructed to always evacuate the	C 022		

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C 022	Continued From page 12 resident that was located closet to the fire. -Staff had been instructed to "holler" at Resident #1, Resident #5 and Resident #6 that there was a fire and to get out of the building. -Resident #1, Resident #5 and Resident #6 could exit the building without any other prompting Observations on 05/31/19 from 2:00pm-3:00pm 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 at ground level Interview with a live-in PCA on 05/31/19 at 2:22pm revealed: -She was always "scared to death" that she would not be able to get all of the residents out of the facility in time if there was a fire because she was the only staff person in the house. -She was concerned because she would be responsible to get the 3 non-ambulatory residents out and make sure the other 3 residents residing in the facility were out safely. Confidential staff interview revealed the staff thought it would be physically impossible to get all of the residents out of the facility if there was a fire because 3 of the residents were completely dependent on staff to exit the facility and then they would still have to make sure the other ambulatory residents responded to the fire alarm and exited the facility. Telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm revealed:	C 022		SP/19 Has hired new employee to Facility Admin has had these Residents in her facility for a long period of time. During State survey told State worker that no other State survey has ever told Facility

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If continuation sheet 13 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL070079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B WING	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 -I here was a major concern with one staff person getting three non-ambulatory residents out of the facility timely in the event there was a fire. -The staff person would have to physically move each non-ambulatory resident out which would take time. -He did not think that one staff person could move three non-ambulatory residents out of the facility and assure all of the other residents had evacuated in time in the event of an active fire. -If the facility had a sprinkler system it would greatly change the scenario and give one-person time to get each resident out of the facility. Interview with the Administrator on 05/31/19 at 3:06pm revealed: -The facility did not have a sprinkler system. -She did not have to have a sprinkler system. -In the day time there were staff within close proximity that could come to help the one staff working in the facility to get residents out of the facility in the event the fire alarm sounded. -She prayed to God there was never a fire in the facility. -She thought the other ambulatory residents residing in the home could evacuate the facility in the event of a fire independently without any staff assistance. -She was licensed for 3 nonambulatory residents but was not aware residents with cognitive impairments were "counted" as nonambulatory residents in the event of an emergency evacuation. 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	C 022	that an extra em ployee had to be present. Facility immediately put some one in place that same day. Admin stated that this is the first time she has ever heard of cognitive impairment also our local DSHS social worker was not aware of it either.	5/31/19

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 of the residents and constitutes a Type B Violation. A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 05/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019	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: TYPE B VIOLATION 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 4 of 6 sampled residents (Resident #1, #2, #3, #4 and #5). The findings are: Review of the facility's current license effective 01/01/19 revealed the facility was licensed 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 05/29/2019.	C 191		

Admin was not aware of this until it was brought to our attention. Admin feels that this rule or DSS social workers should of known

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL078079

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

(X3) DATE SURVEY
COMPLETED

05/31/2019

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 15

C 191

Observation on 05/29/19 at 9:45am revealed one staff member, a live-in personal care aide (PCA) was on duty.

Interview with a live-in PCA on 05/29/19 at 10:03am revealed:

- She was the only staff currently present on duty
- She worked 48 hour shifts that started on Mondays at 2:00pm through Wednesday at 2:00pm, then reported back to work on Friday at 2:00pm and worked until Monday at 2:00pm.
- She slept at night from 10:00pm to 6:00am in the live-in quarters of the facility.

A second interview with the live-in PCA on 05/29/19 at 11:46am revealed:

- The facility had an audible call alarm system that was activated when the residents pulled a "pullstring" that was located at the residents' bedside.
- The call system's main unit hub was located in the live-in's 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 #2's current FL-2 dated 03/07/19 revealed

- Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesophageal reflux disease.

- There was documentation the resident was constantly disoriented.

- There was documentation the resident required total care for personal care assistance from staff

Review of Resident #2's Care Plan dated

About this area—
If Admin would
have been aware
of this rule,
therefore Admin
would or put this
in place.

As of that date
of survey Admin
hired new staff
for night time.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 16 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm revealed -Resident #2 used a mechanical lift for transfers, was not able to ambulate and was totally dependent upon staff for all of her needs. (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). -Resident #2 could not activate the call system for staff help when the resident was in the bed. -She thought Resident #2 could not "comprehend" or know how or when to pull the string if she needed help. -Before she went to sleep at night she always made the sure the call system pull string was not in Resident #2's reach because she was afraid the resident would get tangled in the cord. Interview with a second live-in PCA on 05/30/19 at 3:12pm revealed Resident #2 was not physically or mentally able to call for help using the call system but when she heard her make any noises she would get up and check on her. Telephone interview with Resident #2's family member on 05/31/19 at 4:40pm revealed: -Resident #2 had dementia and was completely dependent on staff for all of her needs. -She was aware staff slept in the facility at night Telephone interview with Resident #2's primary care provider (PCP) on 05/30/19 at 5:22pm revealed: -Resident #2 should have 24-hour care and supervision and would expect staff to be awake in	C 191	As the As the administrator I have always had concerns about all my residents Admin / STC is aware that these residents could not comprehend to pull a string, also the families are and was aware that her facility was a FCL.	

Division of Health Service Regulation

STATE FORM

8800

2B5T11

If continuation sheet 17 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL070079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 17 the facility at all times. -The PCP was unaware the facility had no awake 24-hour staff. -She had safety concerns because some of the residents could not communicate the need for help when the resident needed it. -She expected staff to be awake at all times for the care of the residents. Interview with the Administrator on 05/31/19 at 3:19pm revealed she had no concerns with not having awake staff from 10:00pm to 6:00am to supervise Resident #2. Based on interviews, and record review, it was determined Resident #2 was not interviewable Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm. Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm. Refer to the interview with the Administrator on 05/31/19 at 3:19pm 2. Review of Resident #4's current FL-2 dated 3/21/19 revealed: -Diagnoses included mental retardation, osteoarthritis, hypertension, depressive disorder, other and unspecified hyperlipidemia, esophagitis, and reflex anxiety. -There was documentation the resident was semi ambulatory with a wheelchair. -The was documentation the resident was constantly disoriented Review of Resident #4's Resident Register revealed an admission date of 12/17/2003.	C 191	Staff was would not be aware of 24 hr care due to Admin / SIC was not aware of it either Admin hired new employee the same day!	

Division of Health Service Regulation

STATE FORM

6889

2B5T11

If continuation sheet 18 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:		(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 18 Review of a court document revealed Resident #4 was adjudicated incompetent and appointed a guardian on 06/12/18. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm revealed: -Resident #4 used a mechanical lift for transfers, was not able to ambulate and was totally dependent on staff for all of her needs. (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). -Resident #4 could not tell staff what she needed. -Resident #4 was confused at night. -Resident #4 could not activate the call system when she was in her bed. -She thought Resident #4 could not "comprehend" or know how or when to pull the string if she needed help. -Before she went to sleep at night she always made the sure the call system pull string was not in Resident #4's reach because she was afraid the resident would get tangled in the cord. Interview with a second live-in PCA on 05/30/19 at 3:12pm revealed Resident #4 could not remember how to call for help using the call system but when she heard her make any noises she would get up and check on her. Telephone interview with Resident #4's primary care provider (PCP) on 05/30/19 at 5:22pm revealed: -Resident #4 should have 24-hour care and supervision and would expect staff to be awake in the facility at all times. -The PCP was unaware the facility had no awake 24-hour staff. -She had safety concerns because some of the	C 191			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:		(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 19 residents could not communicate the need for help when the resident needed it. -She expected staff to be awake at all times for the care of the residents. Interview with the Administrator on 05/31/19 at 3:19pm revealed she had no concerns with not having awake staff from 10:00pm to 6:00am to supervise Resident #4. Based on interviews, and record review, it was determined Resident #4 was not interviewable. Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm. Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm. Refer to the interview with the Administrator on 05/31/19 at 3:19pm. 3. 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. -There was documentation Resident #3 was non-ambulatory -There was documentation Resident #3 was intermittently disoriented. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:22pm revealed: -Resident #3 could not walk. -Resident #3 wore 2 liters of oxygen at night. -Resident #3 removed the nasal cannula throughout the night. -Resident #3 did not like to wear his oxygen at	C 191			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 20 night. -Resident #3 required extensive assistance from staff with bathing, dressing, and toileting. -Resident #3 required a one-person transfer using a mechanical lift transfer (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). -She told Resident #3 every night to keep his oxygen in his nose and the resident had his oxygen in his nose the "majority of the time" when she got up at night. Interview with a second live-in PCA 05/30/19 at 3:12pm revealed at one time Resident #3 would not pull his call string to alert staff for help but when Resident #3 needed help he knew to pull his call string cord in his room. Observations of Resident #3 intermittently on 05/29/19 from 9:45am - 11:33am revealed: -The resident was talkative but could not stay focused in conversation and would divert to different off subject conversations. -The resident asked the same question repeatedly. Review of court document dated 05/05/18 revealed Resident #3 was appointed a guardian of the person. Interview with the hospice nurse on 05/31/19 at 11:02am revealed: -The hospice nurse had worked with the resident quite a bit since being under hospice care. -Resident #3 was ordered to wear his oxygen at night that treated multiple diagnoses. -Staff should monitor Resident #3 to make sure his nasal cannula was worn at night. -Oxygen would help Resident #3 rest better at	C 191	Admin / SFC had concerns on how Resident was questioned, knowing that there diagnosis was on already on Fb-2 form. Admin and med-Tech and family members and Doctor was aware of their conditions.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL076079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 night -Supplemental oxygen would help keep Resident #3's oxygen saturations up at night when he was sleeping and lying flat in the bed. -Resident #4's oxygen levels had been in normal range when checked. Telephone interview with Resident #3's primary care provider (PCP) on 05/30/19 at 5:22pm revealed: -Resident #3 should have 24-hour care and supervision and would expect staff to be awake in the facility at all times. -The PCP was unaware the facility had no awake 24-hour staff. -She had safety concerns because some of the residents could not communicate the need for help when the resident needed it. -She expected staff to be awake at all times for the care of the residents. Interview with the Administrator on 05/31/19 at 3:19pm revealed she had no concerns with not having awake staff from 10:00pm to 6:00am to supervise Residents #3. Attempted telephone interview with Resident #3's guardian was unsuccessful on 05/31/19 at 9:05am. Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm. Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm. Refer to the interview with the Administrator on 05/31/19 at 3:19pm. 4. Review of Resident #6's current FL-2 dated	C 191		

Division of Health Service Regulation

STATE FORM

5400

285T11

If continuation sheet 22 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 10/01/18 revealed: -Diagnoses included cognitive impairment, hypertension, traumatic brain injury and hearing deficit. -There was documentation the resident #6 was ambulatory, constantly disoriented and 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. Interview with Resident #6 on 05/29/19 at 11:12am revealed: -He was very hard of hearing and could not hear anything out of his right ear -He did not sleep well at night and had spoken with his primary care provider (PCP) about that. -He had a past history of a head injury, "I don't have a brain that works right". A second interview with Resident #6 on 05/31/19 at 11:02am revealed: -He had seen a string in his room (call string) but did not know what it was for. -When he got up at night he didn't need anything from staff and stayed in his room. Interview with a second live-in personal care aide (PCA) on 05/30/19 at 3:12pm revealed: -Resident #6 had told her he was not sleeping at night and when she did get up at night to check on the residents, Resident #6 was always up in his room or in the shared bathroom. -Resident #6 had "short term memory loss" but	C 191		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 did not come out of his room at night. -Resident #6 shared a bathroom with Resident #4. -She always locked Resident #4's bathroom at night to keep Resident #6 from entering into Resident #4's room because she did not know Resident #6 that well since he had only lived at the facility a short time. -She never saw Resident #6 anywhere in the facility at night except his bedroom or his bathroom when she got up to check on the residents. -Resident #6 had "agitation" at times with staff but she was not aware of Resident #6 having agitation with other residents. -Resident #6 would pace and become verbally loud if staff told him a specific time for something to be done and it was done at the specific time he was told and he would become agitated when he was out of cigarettes. Telephone interview with Resident #6's primary care provider (PCP) on 05/30/19 at 5:22pm revealed: -The PCP was unaware the facility had no awake 24-hour staff. -She expected staff to be awake at all times for the care and supervision of the residents but was not concerned for the ambulatory residents needing staff assistance in the facility at night. Refer to the interview with a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm. Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm. Refer to the interview with Administrator on 05/31/19 at 3:19pm.	C 191		

Division of Health Service Regulation

STATE FORM

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285T11

If continuation sheet 24 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 5. 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 and was ambulatory. Review of Resident #1's Care Plan dated 10/19/18 revealed: -Resident #1 required limited assistance from staff with bathing, dressing, and grooming, was independent with eating, ambulation, and transferring, and supervision with toileting. -Resident #1 was receiving mental health medication. Interview with Resident #1 on 05/31/19 at 11:08am revealed he knew there was a string to pull to call staff in his room but he had never used it. Interview with a live-in personal care aide (PCA) on 05/30/19 at 3:12pm revealed: -Resident #1 did not wander inside the facility or try to go outside at night after the door alarms were activated. -Resident #1 did not need staff assistance at night and was able to do all of his care independently. Telephone Interview with Resident #1's primary care provider (PCP) on 05/30/19 revealed: -The PCP was unaware the facility had no awake 24-hour staff. -She expected staff to be awake at all times for the care and supervision of the residents but was not concerned for the ambulatory residents needing staff assistance in the facility at night.	C 191		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 a live-in PCA on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm. Refer to the interview with a second live-in PCA on 05/30/19 at 3:12pm. Refer to the Interview with Administrator on 05/31/19 at 3:19pm. Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm -She was a "light sleeper" and did not sleep all night. -She always slept with her door opened at night. -She would get up if she heard a "cough or something" but sometimes she did not get up at all to check on the residents. Interview with a second live-in PCA on 05/30/19 at 3:12pm revealed: -She did not sleep well at night and always got up at least twice during the night to check on the residents. -She typically activated the door alarms around 9:50pm, went to bed around 10:00pm and got up around 6:00am the next morning. Interview with the Administrator on 05/31/19 at 3:19pm revealed she was not aware awake staff were required 24 hours a day for the supervision of residents with physical or cognitive limitations, "that's new to me" The facility failed to have awake staff on duty and awake at all times to meet the supervision and personal care needs for 4 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	C 191		

*Admin did not fail
to have awake staff
on duty @ All times
due to reg.*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
C 191	Continued From page 26 Type B Violation. A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 05/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019.	C 191	was unaware. But Admin put someone in place the same way!
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up with the primary care provider for 1 of 4 sampled residents related to a resident having trouble swallowing her food for at least a week (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 3/21/19 revealed: -Diagnoses included mental retardation, osteoarthritis, hypertension, depressive disorder, other and unspecified hyperlipidemia, esophagitis, and reflex anxiety -There was documentation that the resident was semi ambulatory with a wheelchair. -There was documentation that the resident was constantly disoriented.	C 246	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 246	Continued From page 27 : -There was an order for no added salt diet. Review of Resident #4's resident register revealed an admission date of 12/17/03. Review of a court document revealed Resident #4 was adjudicated incompetent and appointed a guardian of the person on 06/12/18 Review of Resident #4's Care Plan dated 12/11/18 revealed the resident requires extensive assistance with eating. Observation Resident #4's lunch meal on 5/29/19 from 12:30 - 12:45pm revealed: -The resident fed herself. -The resident coughed constantly while eating The resident made a constant gurgling sound while eating. - The resident gagged while eating. Observation of Resident #4's dinner meal on 5/29/19 at 5:00pm - 5:15pm revealed: -The resident fed herself. -Resident #4 begun coughing after her first bite of food. -Resident #4 coughed constantly while eating. -Resident #4 made a constant gurgling sound while eating. -Resident #4 gagged while eating. -The live-in personal care aide (PCA) was in the room during this time. -The live-in PCA was providing feeding assistance to another resident. -The live-in PCA observed Resident #4 had trouble swallowing her food. -The live-in PCA asked Resident #4 if she was "alright". -The live-in PCA encouraged Resident #4 to drink her beverage when coughing.	C 246	<i>The Admin planned and did contact Doctor to let her be aware of #4 eating problems. Admin Doctor faxed over order to chopp #4 food.</i>	

Division of Health Service Regulation
STATE FORM

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If continuation sheet 28 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 246	Continued From page 28	C 246		
	Interview with the live-in PCA on 5/30/19 at 9:20am revealed: -She had noticed Resident #4 having trouble swallowing last week. -She felt that Resident #4 needed a "swallowing test". -Resident #4 "chewed her food she then pushed the food down with her tongue instead of being able to swallow it normally". -She had noticed Resident #4 no longer ate all her food as she used too due to trouble swallowing. -She had not reported Resident #4's swallowing issue to anyone. -She did not document any of her observations or concerns because she did not have a notebook. -There was no system in place of documenting concerns. -Typically, she notified the medication aide/supervisor in charge (MA/SIC) of concerns during his medication pass. -At times she forgot to tell the MA/SIC because she was "too busy". Interview with the MA/SIC on 5/31/19 at 4:02pm revealed: -He had not noticed Resident #4 having trouble swallowing. -The live-in staff had not made him aware. -Had he known of the swallowing difficulty he would have made Resident #4's primary care provider (PCP) aware. Interview with the Administrator on 5/30/19 at 3:46pm revealed: -She was not aware of Resident #4 had trouble swallowing food. -She or MA/SIC would talk with Resident #4's PCP had she been made aware.		Admon spoke to other PCS worker, and she stated she hadn't seen any kind of off problems E #4 eating her food. Admin/STC had meeting with both employee to discuss when they see	

If continuation sheet 30 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUI/DING: B. WING	(X3) DATE SURVEY COMPLETED 05/31/2019
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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 246	Continued From page 30 delayed diagnostic testing to assess and treat the resident's swallowing difficulties. This failure was detrimental to the health, welfare and safety of the resident which constitutes a Type B Violation A Plan of Protection was submitted by the facility in accordance with G.S. 131D - 34 on 5/31/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019.	C 246	but contacted Doctor 4/10 Satm day. Also Admin @ contacted family	
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 sampled resident who was diagnosed with advanced dementia and had an order for a pureed diet (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 03/07/19 revealed -Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep	C 284	member At well.	

Division of Health Service Regulation

STATE FORM

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If continuation sheet 31 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 284	Continued From page 31 vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesophageal reflux disease. -There was an order for a no concentrated sweet (NCS) pureed diet. -There was documentation the resident was constantly disoriented. -There was documentation the resident required "total care" for personal care assistance from staff. Review of Resident #2's Assessment and Care Plan dated 03/07/19 revealed: -There was documentation the resident was always disoriented and had a significant memory loss and required direction. -There was documentation the resident required extensive assistance from staff with eating. Review of the facility's diet list posted on the refrigerator in the facility's kitchen on 05/29/19 at 12:05pm revealed Resident #2 was on a NCS, pureed diet. Interview with a live-in personal care aide (PCA) on 05/29/19 at 12 06pm revealed: -She made sure Resident #2's foods were cut into "smaller pieces" and she had been doing that for "years". -She thought Resident #2 was on a pureed diet at one time because the resident could not swallow. -She was aware the facility's diet list posted in the kitchen indicated that Resident #2's current diet order was for a pureed, no concentrated sweet diet. -She was told by the Business Office Manager (BOM) that Resident #2's food did not have to be pureed unless "I wanted" to puree the resident's foods. -She usually did not puree Resident #2's foods	C 284			

Admin / SIC met
Something in place
@ that time and
A note made
Employee aware

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 284	Continued From page 32 because the resident would not eat it and would spit the food back out if pureed. Observation of Resident #2 during the lunch meal on 5/29/19 at 12:07pm revealed: -Resident #2's food was prepared by the live-in personal care aide (PCA). -Resident #2's food was not pureed. -Resident #2 was served turkey, gravy, bow tie noodles, mashed potatoes, green beans, roll and mandarin oranges. -The live-in PCA sat beside Resident #2 and assisted the resident to eat the meal. -The live-in PCA used a spoon to cut the food up in small pieces before placing the food on the spoon and fed Resident #2 the foods cut into small pieces. -Resident #2 made movements with her bottom jaw then swallowed the food without any observed difficulty. -Resident #2 ate 100% of the plated food. Observation of a second live-in PCA on 05/29/19 at 4:27pm revealed: -The live-in PCA aide placed a cooked hamburger that was broken into pieces, bread and water in a blender. -The live-in PCA left the blender running to puree the foods while she assembled the food on plates for the other residents. -The live-in PCA stopped the blender and stirred the food and added more water and mayonnaise to the food and started the blender again to puree the food. -After approximately 2 minutes, the live-in PCA stopped the blender and plated the pureed hamburger, bread and mayonnaise. -The food was in a pureed consistency. -The live-in PCA pureed cooked French fries and water in the blender and stopped the blender at	C 284	And went over diet order to employee.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10	STREET ADDRESS, CITY, STATE, ZIP CODE 70 CARE DRIVE PEMBROKE, NC 28372
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C 284	Continued From page 33 intervals and would shake the blender's glass canister and restart the blender until the food was in a mashed potato consistency, then plated the pureed French fries and used a fork to mash through the French fries. Observation of Resident #2 during the dinner meal on 5/29/19 at 5:00pm revealed: -The resident was served pureed hamburger/bun with mayonnaise, French fries, and apple sauce. -The second live-in PCA sat beside Resident #2 and assisted the resident to eat the meal. -Resident #2 swallowed the food without any observed difficulty. Interview with the second live-in PCA on 05/29/19 at 5:30pm revealed: -Resident #2 was on a pureed diet. -She always pureed all of Resident #2's foods before serving and feeding the resident. -She thought it was important for the foods to be in a "smooth", "pudding like" consistency with "no chunks" of food, so the resident could swallow the foods easily. -She had received training from "a lady" a few years ago (unable to recall the exact time) and had to demonstrate to the "lady" how to puree foods. -She knew what ordered diet each resident was on by referring to the diet list posted on the refrigerator. -She never saw any of the residents' diet orders but the BOM was responsible for updating the residents' diet order on to the posted diet list. -She occasionally would shake the blender's canister to make sure the foods were not on the side of the canister and to make sure the foods were in direct contact with the blades to remove any food chunks and pieces.	C 284		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 284	Continued From page 34 Telephone interview with Resident #2's guardian on 05/31/19 at 4:40pm revealed: -Resident #2 had suffered a stroke and since then had been on a pureed diet and her speech was also effected by the stroke. -There was one of the live-in PCAs (named as the live-in PCA that was observed on 05/29/19 that pureed the dinner meal for Resident #2) who was "a little more afraid" when she assisted Resident #2 with eating than the other live-in PCA that worked in the facility. -She had visited when the other live-in PCA did not puree Resident #2's food and chopped "the food up good" instead of serving the food to the resident in a pureed consistency. -The guardian had not observed Resident #2 having any difficulty swallowing food that was not in a pureed consistency, no observations of the resident coughing during a meal. Interview with the BOM on 05/30/19 at 5:00pm revealed: -She was responsible for updating the diet list for the facility which showed the latest diet ordered by the residents' primary care provider (PCP). -The live-in PCAs were responsible for preparing the residents' meals according to the diet list. -She had not instructed the live-in PCAs not to puree Resident #2's food. -It was very important for Resident #2 to have her foods pureed so the resident would not choke. -She did not physically monitor the meals served to the residents unless she was in the facility during the residents' meals. -She had not observed staff serving foods that were not pureed. A second interview with the live-in PCA that served Resident #2 food on 05/29/19 that was not pureed on 05/31/19 at 2:22pm revealed:	C 284		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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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)	(X6) COMPLETE DATE
C 284	Continued From page 35 -Resident #2 could eat anything and ate better when she did not puree the resident's food. -She would not give Resident #2 anything to eat that she thought would hurt her. -She was not aware that a PCP's order was needed to serve Resident #2's a chopped diet instead of a pureed diet -Resident #2 never coughed, choked or seemed to have any problems when eating chopped food. -The Administrator, medication aide/supervisor-in-charge (MA/SIC) and the BOM did not monitor the residents' meals or the preparation of the residents meal unless they just "pop in" when she was preparing or serving the residents' meals Interview with the MA/SIC on 5/31/19 at 4:06pm revealed: -It was the responsibility of the office staff which includes the Administrator and BOM to ensure diet orders were being followed as ordered. -He was not aware that Resident #2's meals were not always being served pureed. -The live-in staff were aware that they were supposed to puree Resident #2's foods. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Interview with the Administrator on 5/31/19 at 3:06pm revealed: -She never provided instruction concerning pureed diets -Puree was the easiest diet order to follow. -There was no training provided to staff on the preparation of therapeutic diets. -Office staff posted the diet orders in the kitchen for live-in PCAs to follow -When a residents' diet order changed it was updated on the diet list, posted in the kitchen and	C 284		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 70 CARE DRIVE PEMBROKE, NC 28372		
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C 284	Continued From page 36 verbally given to live-in staff by the BOM and administrative staff. -She was not aware that the live-in PCA aide was not following Resident #2's therapeutic diet order. -Her expectation was that Resident #2's food be prepared as directed by the diet order. Telephone interview with Resident #2's PCP on 05/30/19 at 5:22pm revealed: -Resident #2 was placed on a pureed diet for aspiration precautions because of advanced Alzheimer's disease. (Aspiration is when foods or fluids get into a persons airway which could lead to trouble breathing, lung infections and pneumonia. Aspiration precautions are practices which that help prevent foods or fluids from getting into a persons airway). -She expected staff to follow the residents' diet orders that had been given. The facility failed to assure therapeutic diets were served as ordered for Resident #2 who was ordered to receive pureed foods for aspiration precautions and was observed receiving chopped foods during a meal observation. The facility's failure to assure Resident #2 received pureed foods was detrimental to the health and safety of the resident, which constitutes a Type B Violation. A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 05/30/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 15, 2019	C 284		
C 311	10A NCAC 13G .0909 Residents' Rights	C 311		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 05/31/2019
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C 311	Continued From page 37 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21. Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the safety of residents as evidenced by staff failing to report feeling uncomfortable using Resident #2's mechanical lift device, failing to operate the mechanical lift device properly by failing to stabilize the lift when transferring residents and failing to have an ongoing monitoring process in place to assure the mechanical lifts were used correctly by staff and worked properly The findings are Review of Resident #2's current FL-2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's disease, dementia, anemia, gastrointestinal bleed, deep vein thrombosis, hypertension, atrial fibrillation, insulin dependent diabetes mellitus, gastritis and gastroesophageal reflux disease. -There was documentation the resident was constantly disoriented. -There was documentation the resident required "total care" for personal care assistance from staff. Review of Resident #2's Resident Register revealed an admission date of 04/07/11.	C 311	Admin / SIC / med-ten knew that employee had been trained on using a Hoyer lift. employee had been 5/31/19 using a Hoyer lift for years. Admin was not aware that staff was not comfortable on using one.		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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C 311	Continued From page 38 Review of Resident #2's assessment and care plan dated 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluations revealed: -The resident's LHPS tasks included mechanical lift transfers. (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). -There was documentation staff were competency validated for the quarterly reviews dated 04/08/19, 01/07/19, 12/06/18, 09/05/18, and 06/08/18 for mechanical lift transfers. Review of an "Accident/Incident Report" for Resident #2 dated 02/27/19 revealed: -The resident was assisted to her room by staff around 8:00pm on 02/17/19. -The staff "hooked up net to place the resident in bed" and realized there was one "hook" the staff forgot to "hook" and the resident fell to the floor. -The staff contacted the Administrator and then called 911. -The Administrator contacted Resident #2's family member. -The resident was admitted to the hospital with a right hip fracture. -There was documentation the Administrator completed and signed the form. Review of Resident #2's hospital Inpatient Discharge Summary revealed: -The resident was admitted on 02/27/19 and discharged on 03/06/19. -There was documentation the resident's discharge diagnosis was a right hip fracture	C 311	If Admin or SFC have been of aware Admin would have admittedly contacted proper training for that employee. Admin admittedly contacted RN and had training on that that employee.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL078079

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING

(X3) DATE SURVEY
COMPLETED

05/31/2019

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
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DEFICIENCY)

(X5)
COMPLETE
DATE

C 311 Continued From page 39

C 311

secondary to a mechanical fall
-In the hospital course section of the Summary
there was an entry on 02/27/19, the resident was
placed in a mechanical lift and moved off her bed
in order to be cleaned. The resident was not well
secured "within the left" and the resident tumbled
to the floor.

-On 02/24/19 an x-ray of the resident's hip and
pelvis showed a minimally displaced fracture of
the right hip.

-The resident underwent a surgical procedure for
a intramedullary nail fixation of the right hip (a
metal rod forced into the cavity of the bone to
treat the fracture).

Observation of the live-in personal care aide
(PCA) assisting Resident #2 with transferring
using a mechanical lift on 05/29/19 at 9:34am
revealed:

-Resident #2 was pushed in a Geri-chair to her
bedroom by the live-in PCA.

-Resident #2's bed was against the left long wall
of the room.

-The live-in PCA positioned Resident #2's
Geri-Chair beyond the bed and turned the
Geri-chair sideways passed the end of the
resident's bed. The live-in PCA pushed the
wheels of the Geri chair in alignment with the
chair and locked the wheels.

-The live-in PCA rolled a white colored
mechanical lift base underneath the Geri-chair,
then stopped.

Interview with the live-in PCA on 05/29/19 at
9:37pm revealed:

-The white colored mechanical lift belonged to
Resident #2.

-She did not like this mechanical lift because it did
not have clips and she "was not comfortable"
using it but was more comfortable using the blue

Admin / SIC contacted
Resident POA and
explain to her

what happen also
did accident report

and fax over to DSS.

Admin / SIC did meet

to all staff and

checked employee

Books to ensure

that proper documentation

was in the Books

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL078079

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____

B. WING: _____

(X3) DATE SURVEY
COMPLETED

05/31/2019

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
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(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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C 311 Continued From page 40

C 311

colored lift.

-She thought she had to use Resident #2's white colored mechanical lift today (05/30/19) during the observation of Resident #2's transfer but never used Resident #2's lift and always used the blue colored mechanical lift that belonged to another resident in the facility to transfer Resident #2

A second observation of the live-in PCA assisting Resident #2 with transferring using the blue colored mechanical lift belonging to another resident on 05/29/19 at 9:38am revealed:

-The live-in PCA removed the white colored mechanical lift from Resident #2's room and brought in a blue colored mechanical lift.

-The live-in PCA told Resident #2 she was going to transfer her from the Geri-chair to the bed.

-Resident #2's transfer mesh sling was positioned underneath the resident in the Geri-chair.

-The live-in PCA straightened the sides and corners of the meshed sling positioned underneath Resident #2 and checked the positioning of the sling underneath the resident's upper back, sides and knees.

-The live-in PCA rolled the base of the mechanical lift under the Geri-chair and positioned the spreader bar over the center of the patient with the hooks facing away from the resident. The mechanical lift legs were not in an opened position.

-The live-in PCA hooked the color-coded sling loops onto the spreader bar with the red colored loops to support the top portion of the resident and the black colored loops to support the resident's lower portion, then checked each sling loop on the hook with the clips by walking on both sides of the chair checking each loop.

-The live-in PCA checked the pressure knob, slowly used the hand crank to the mechanical lift

Med-Tech contacted
DME to order

a new hoyer lift
that day.

Admin / SFC plans

to ensure to meet

T all staff about

each resident

and how important

it is to ensure

that it for them

STATEMENT OF DEFICIENCIES
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C 311 Continued From page 41

C 311

to raise Resident #2 from the Geri-chair and once cleared checked the pressure knob again to assure it was secure and in position, then moved the mechanical lift away from the Geri-chair and slowly positioned the mechanical lift toward the bed while guiding the resident's movement in the suspended sling until the resident was positioned in the sling over the bed.

-The live-in PCA centered Resident #2 over the bed and rotated the resident to face the foot section of the bed then slowly released the pressure knob and guided the resident onto the bed.

-During the transfer the live-in PCA did not widen the base of the mechanical lift legs to the maximum opened position.

A second interview with the live-in PCA on 05/30/19 at 9:41am revealed:

-She stopped using Resident #2's white colored mechanical lift in February 2019 after the resident fell from the lift.

-She was assisting Resident #2 back to the bed from the Geri-chair and became distracted by another resident that came to Resident #2's door asking her for a glass of milk as she was securing the resident's sling loops to lift and transfer the resident.

-She remembered as she turned around to tell the other resident she would be right there, she then noticed she had not placed any incontinent linen savers on Resident #2's bed and stopped in the process of securing the sling loops to place the incontinent linen savers on the bed.

-When she went back to complete Resident #2's transfer using the mechanical lift, she did not double check to assure all of the loops were secured and did not realize one of the bottom straps was not fastened.

-Resident #2 was lifted in the sling using the

Safety!

Admin/STC followed
E staff and
watched employee
use Hoyer lift
and was signed
off on.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:		(X3) DATE SURVEY COMPLETED 05/31/2019
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 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 311	Continued From page 42 mechanical lift and when she pulled the lift away from the chair, Resident #2 fell out of the sling and onto the floor -Since Resident #2 fell from the lift she now always physically walks around the chair or bed to make sure all of the sling loops were hooked and secured instead of just leaning over to check the hooks. -She had not used Resident #2's white colored mechanical lift since the incident in February 2019. -She had never felt comfortable using Resident #2's mechanical lift "anyway" because it did not hook the sling loops like the other residents' lifts. -She had never mentioned to the Administrator or to the medication aide/supervisor-in-charge (MA/SIC) that she was uncomfortable using Resident #2's mechanical lift. -She had worked for the facility since 2007. -She did not have any prior PCA experience and no previous experience operating a mechanical lift when she was initially hired. -She received on the job training from a co-worker for the use of the residents' mechanical lifts. -She thought years ago she had to do a return demonstration using a residents' mechanical lift for someone but was not sure if she was observed or passed off by a nurse or medical professional. -She "seldom" widened the lift's base to the maximum opened position when transferring residents' in the mechanical lifts. -She had to narrow the mechanical leg base to fit the lift under the Geri-chair -She did not know that widening the base of mechanical leg lifts stabilized the lift to prevent the lift from falling over. -She could not remember a time that the Administrator nor the MA/SIC had observed her	C 311			

Division of Health Service Regulation

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C 311	Continued From page 43 during the entire process of transferring a resident using a mechanical lift from start to finish. A third observation of the live-in PCA on 05/30/19 at 2:04pm revealed: -The live-in PCA assisted another resident sitting in a wheelchair to her room. - The live-in PCA locked the wheels of the wheelchair and explained to the other resident that she was going to transfer her from the wheelchair to the bed. -The live-in PCA widened the base of the mechanical lift legs as she positioned the lift around the front of the resident's wheelchair and kept the lift legs in the maximum opened position during the resident's complete transfer from the wheelchair to the bed. A third interview with the live-in PCA on 05/30/19 at 2:10pm revealed: -Since the incident occurred in February 2019 with Resident #2 falling out of the mechanical lift she was not in a "hurry anymore" when she transferred residents using mechanical lifts and had started practicing safety checks to make sure everything was secure and in position before transferring and moving residents in mechanical lifts -She did not know if there was an owner's manual available for instructions on the use of Resident #2's mechanical lift or an owner's manual for use instructions for the other two mechanical lifts in the home that belonged to the other residents. -No one had ever reviewed step by step instructions with her on the use and safety precautions that should be used when operating and transferring a resident using a mechanical lift. -She had spoken with Resident #2's hospice		C 311		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

DIAL'S FAMILY CARE HOME #10

70 CARE DRIVE
PEMBROKE, NC 28372

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C 311	Continued From page 44 provider today (05/30/19) to see if the resident could qualify for a new mechanical lift because the resident had this same mechanical lift for years. Observation of Resident #2's mechanical Lift on 05/30/19 at 10:05am revealed: -There was sticker on the center bar of the mechanical lift that provided a number for service of the lift and the name of the durable medical equipment provider (DME) -There was a suspended spreader bar with six-point curved hooks to attach the patient lift sling that was not equipped with clips at the end however the bar hooks were curved and elongated. -The serial number sticker was worn and unreadable. Attempted telephone interview with the DME company for Resident #2's mechanical lift on 05/30/19 at 7:00pm and on 05/31/19 at 2:08pm was unsuccessful A second observation of Resident #2's mechanical Lift on 05/31/19 at 3:12pm revealed: -There was a labeled "Caution" sticker with instructions printed in red font -There were instructions trained caregivers only should operate the equipment. -Whenever possible two caregivers should be present during lifting and transferring. -To ensure safety, frequent inspections of this equipment and its accessories should be performed by a qualified maintenance staff to detect wears and tears and worn parts replaced. -Operating details were referred to the Owner's manual. Observation of the mechanical lift used to transfer	C 311		

Division of Health Service Regulation

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C 311	Continued From page 45 Resident #2 on 05/30/19 revealed a 6-point hooks with movable clips at the ends on the suspended spreader bar. Review of an online Owner's manual for the mechanical lift used to transfer Resident #2 on 05/30/19 revealed: -Before using the lift, please read and adhere to the safety precautions and warnings. Failing to do so could result in serious personal injury or damage to your personal lift. -Protect yourself, your attendant and the patient lift by having it serviced regularly. -There was an entry labeled "WARNING" patient lifts may tip over if used incorrectly. Read and adhere to the operating instructions prior to lifting anyone. There was a second entry labeled "WARNING" that it was strongly recommended that two caregivers take part in the lifting process. -There was a third entry labeled "WARNING" to ensure stability while lifting and transferring a patient, the patient lift legs must be locked in the maximum open position. -There was a fourth entry labeled "WARNING" to ensure the lifting sling loops were correctly attached to the hooks to prevent the patient from sliding or falling out of the sling, which could result in personal injury. Interview with the Administrator on 05/30/19 at 3:50pm revealed: -The facility did not have a written policy and procedure for the use of the residents' mechanical lifts and "they" just had the staff checked off on the use of the mechanical lifts before the staff used the lifts. -She was not aware that the live-in PCA was not comfortable using Resident #2's mechanical lift and did not know she was not using it.	C 311		

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DEFICIENCY)(X6)
CORRECTIVE
DATE

C 311 Continued From page 46

C 311

-She thought the live-in PCA observed transferring Resident #2 today (05/30/19) had received training and was passed off to use a mechanical lift when she first began her employment at the facility.

-She had observed the live-in PCA transfer a resident in a mechanical lift in the past but could not provide a date.

-She thought additional training would be needed and that "maybe it was her fault" that she had not provided any additional training for staff after the incident occurred when Resident #2 fell out of the mechanical lift in February 2019.

-She would have expected for staff to inform her immediately if they were not comfortable using any equipment including mechanical lifts.

-She did not know that the live-in PCA was not routinely widening the base of the lift when transferring residents.

Interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm revealed:

-She was not aware of a process or procedure the facility had to ensure all resident equipment including mechanical lifts had been serviced or working properly.

-She thought "we" needed to put something into place to have the equipment suppliers come to the facility to make sure the mechanical lifts were serviced and working properly.

-She was not aware that any of the staff in the facility did not feel comfortable with Resident #2's mechanical lift.

Interview with Resident #2's hospice nurse on 05/31/19 at 10:57am revealed:

-She never saw staff at the facility use Resident #2's mechanical lift because the resident was always up in the Geri-chair when she visited.

-It would be very important for the residents'

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
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70 CARE DRIVE
PEMBROKE, NC 28372

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(X5)
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C 311 Continued From page 47

C 311

safety for staff to report if they were not
comfortable using Resident #2's mechanical lift.

Telephone interview with the facility's contracted
LHPS nurse on 05/31/19 at 1:58pm and at
4:02pm revealed:

- She recently started providing LHPS quarterly
reviews for the facility around the Fall of 2018.
- She had not "signed off" on the staffs' skills to
perform mechanical lift transfers.
- The facility should have a system in place to
monitor staff using mechanical lifts to make sure
the proper techniques and safety steps were
followed by staff to protect the residents' safety.
- All mechanical lifts came with an instruction
manual but most of the mechanical lifts were the
same.

Interview with the MA/SIC on 05/31/19 at 4:09pm
revealed:

- The facility did not have a policy for the use of
the residents' mechanical lifts used for
transferring.
- There were no manuals available for the
residents' mechanical lifts.
- The previous nurse that done training for staff
and the facility's LHPS quarterly reviews had
passed away.
- The residents' mechanical lifts were not on a
scheduled service plan
- Typically, he would ask the DME supplier to look
at the lifts when they made visits to the facility to
bring other DME equipment.
- He remembered a DME staff person did look at
Resident #2's mechanical lift about 2 months ago.
- The staff using the mechanical lifts in the facility
would be responsible to report if a mechanical lift
was not working properly.
- The live-in PCA had not made him aware that
she was uncomfortable and not using Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/31/2019
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C 311	Continued From page 48 #2's mechanical lift for transfers. -He just had a meeting the first of May 2019 and asked the live-in staff if they had any concerns with any resident equipment and no one mentioned any concerns. -A registered nurse (RN) had been contacted today (05/31/19) to pass off and train staff in the use of the mechanical lifts used to transfer the residents. The RN was scheduled to come Monday 06/03/19. -If he had known the live-in PCA was not comfortable using Resident #2's mechanical lift then he could have had a refresher course set-up for the staff. Interview with a second live-in PCA on 05/31/19 at 2:22pm revealed: -She used Resident #2's mechanical lift and did not have any problems using it. -If she saw a problem with any residents' equipment then she would not use it and report it immediately to the MA/SIC or the Administrator. -Resident #2's mechanical lift was "old" and never had any clips on the end of the hooks. -She was not aware of a owner's manual for Resident #2's mechanical lift. -The hook bars on Resident #2's mechanical lift were designed longer to connect the sling and secure the sling into place. -She always "tugged" down on the loops to make sure the loops were secure and against the hooks bar before lifting Resident #2 with the mechanical lift. -She was trained and had to give a returned demonstration how to use a mechanical lift to transfer a resident when she started back in 2017. -She did not know that widening the base of the mechanical lift ensured the stability of the lift during transfers and could have been told that in	C 311		

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PEMBROKE, NC 28372(X4) ID
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DATE

C 311 Continued From page 49

C 311

training, but was not sure.

Interview with the Administrator on 05/31/19 at
3:22pm revealed:

- She did not monitor the mechanical lifts to assure the lifts were working properly because the live-in PCAs working with the lifts would know if the lift was working properly or not.

- She had seen one of the live-in PCAs use a mechanical lift to transfer a resident in the last 2 weeks and the base of the mechanical lift was widened.

Telephone interview with Resident #2's primary care provider (PCP) on 05/30/19 at 5:22pm revealed:

- She expected staff to always assure the transfer sling to a mechanical lift was well secured prior to transferring a resident.

- If a staff person felt uncomfortable using Resident #2's mechanical lift then that should have been reported immediately to the Administrator for the safety of the resident.

- It was important for all staff to be trained on the use of any equipment prior to use.

The facility failed to assure the safety of residents as evidenced by staff failing to report feeling uncomfortable using Resident #2's mechanical lift device, failing to operate the mechanical lift device properly by not following safety steps when transferring residents and failing to have an ongoing monitoring process in place to assure the mechanical lifts were used correctly by staff and worked properly. The facility's failure which resulted in Resident #2 being dropped while being transferred by a staff who did not follow safety protocol. The facility's failure resulted in Resident #2 sustaining a hip fracture and constitutes a Type A1 Violation for serious

Admin / STC was not aware of employee, not feeling comfortable, Admin / STC assumed mistake can happen, but interviewed

STATEMENT OF DEFICIENCIES
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DATEC 311 Continued From page 50
physical harm and neglect,A Plan of Protection was submitted by the facility
in accordance with G.S. 131D 34 on 05/31/19.CORRECTION DATE FOR THE TYPE B
VIOLATION SHALL NOT EXCEED JUNE 30,
2019

C 311

employee and she
stated she was
comfortable using
the care she used.

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, healthcare referral
and follow up, nutrition and food service and
design and construction.

The findings are:

1. Based on observations, interviews and record
reviews, the facility failed to assure therapeutic
diets were served as ordered for 1 of 1 sampled
resident who was diagnosed with advanced
dementia and had an order for a pureed diet
(Resident #2). [Refer to Tag 204 10A NCAC 13G
0904(e)(4) Nutrition and Food Service (Type B

C 912

Admin / SFC explain
the importance that
they are to react
out to employee
due to the safety
of our residents.

STATEMENT OF DEFICIENCIES
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DATEC 912 Continued From page 51
Violation]].

C 912

2. 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)].

3. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up with the primary care provider for 1 of 4 sampled residents related to a resident having trouble swallowing her food for at least a week (Resident #4). [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type B Violation)].

4. 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 4 of 6 sampled residents (Resident #1, #2, #3, #4 and #5). [Refer to Tag 0191 10A NCAC 13G .0601(d) Management and Other Staff (Type B Violation)].

C 914 G.S 131D-21(4) Declaration Of Resident's Rights

C 914

Every resident shall have the following rights:
4. To be free of mental and physical abuse, neglect, and exploitation.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to Residents' Rights

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL078073

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

B. WING:

(X3) DATE SURVEY
COMPLETED

05/31/2019

NAME OF PROVIDER OR SUPPLIER

DIAL'S FAMILY CARE HOME #10

STREET ADDRESS, CITY, STATE, ZIP CODE

70 CARE DRIVE
PEMBROKE, NC 28372(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETE
DATE

C 914 Continued From page 52

The findings are:

Based on observations, interviews and record reviews, the facility failed to assure the safety of residents as evidenced by staff failing to report feeling uncomfortable using Resident #2's mechanical lift device, failing to operate the mechanical lift device properly by failing to stabilize the lift when transferring residents and failing to have an ongoing monitoring process in place to assure the mechanical lifts were used correctly by staff and worked properly. [Refer to Tag 311 10A NCAC 13G .0809 Residents' Rights (Type A1 Violation)].

C 914

9/31/19

RESIDENT SELECTION
(Clean Copy for Facility & Team Leader)

Facility Name: Dialston Hc Date of Survey: 08/19/19

License #: 101-0804 Licensed Capacity: 6 Current Census: 6

Resident Selection:

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]
4. [REDACTED]
5. [REDACTED]
6. [REDACTED]
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 16, 2019

Bobbie Dial, Executive Officer
Dial's Family Care, Inc., Licensee
Dial's Family Care Home #10
P.O. Box 4134
Pembroke, N.C. 28372

email address: dialfamily2478@aatt.net

RE: **Return of Statement of Deficiencies dated May 31, 2019 - Plan of Correction not accepted (2BST11)**

Facility: Dial's Family Care Home #10
Licensure Number: FCL-078-079
County: Robeson

*Before 6-1-19
before July 15, 2019*

Dear Mr. Dial:

Thank you for responding to the Statement of Deficiencies for the survey completed May 31, 2019 at your facility. We are returning your response for the following reasons:

- _____ 1. The report has not been signed under Provider's Representative Signature.
- _____ 2. The date was not entered for the Provider's Representative Signature.
- ☒ 3. The completion dates for the provider's response were omitted: C191, C246, C284,
- ☒ 4. The completion dates are unacceptable for Findings: C022, C311
- ☒ 5. The provider's response does not include the methods to be used for monitoring and evaluating the corrective action to be implemented.
- ☒ 6. The provider's response is not acceptable for Findings # C191, C246, C284, C022, C311. Please revise in keeping with the directions contained in the cover letter.

Continued failure to submit an acceptable plan of correction does not prevent a follow up survey to the rule areas cited to determine compliance.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION

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www.ncdhhs.gov/dhar/acls • TEL: 919-855-3766 • FAX: 919-733-0370

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7/18/19

#10

Went over diet orders to Mrs.

[REDACTED]

Twice. Also

Administrative Ask her again is

She done w/ the diet orders

and she started yes.

[REDACTED]

[REDACTED]

7/10/19

Fire ext. went over to

[REDACTED]

Admin watched employee and trained

employee on how to use it

[REDACTED]

Holler - Lift employee demonstrated
very well on the use of equipment

[REDACTED]

Fire Rehearsal Schedule

#10

Name of Home T-4

Address

FCH

1. Date 7/8/9

Time 9:18 AM

Person in Charge [redacted]

Other staff present [redacted]

Time for Evacuation 2 min 32 sec

Brief description of what was involved 3 non-amb residents were
sitting in living room staff yelling fire from
kitchen 3 non-amb residents exit out front door and
over 3 amb w/ @ 11:15 AM

Fire Rehearsal Schedule

Name of Home

Address

FCH

1. Date

Time

Person in Charge

Other staff present

Time for Evacuation

Brief description of what was involved

7/18/19

JP

Ask employee was there any

concerns about any of these

pts etc. weight

weakness

extra problems

Told employee to always let office

staff and not take care of

any problems due to not RTR

[REDACTED]

Fire extinguisher check

[illegible]

74111
Dials Family Care
1685 Canal Rd.
Pembroke N.C. 23372

[REDACTED] a Employee at Dials Family Care
understands the policy and the procedures due to using a fire
extinguisher due to a fire. Incase of a fire I understand all procedures
to perform in getting my patients out the building. If I am not
comfortable at any giving time with the policies and procedures I
will let office staff be notified as soon as possible.
Incase there is a fire at any given time there is office staff on property
24/7 with assisting with the help of getting patients out the building.
Office staff and numbers are provided below:

[REDACTED]

2/1/26
Dials Family Care
1685 Canal Rd.
Pembroke N.C. 23372

[REDACTED] Employee at Dials Family Care
understands the policy and the procedures due to using a fire
extinguisher due to a fire. Incase of a fire I understand all procedures
to perform in getting my patients out the building. If I am not
comfortable at any giving time with the policies and procedures I
[REDACTED] will let office staff be notified as soon as possible.
Incase there is a fire at any given time there is office staff on property
24/7 with assisting with the help of getting patients out the building.
Office staff and numbers are provided below:

[REDACTED]
[REDACTED]
[REDACTED]

Name of Home 1012

FCH

Address _____

I Date 7-1-77

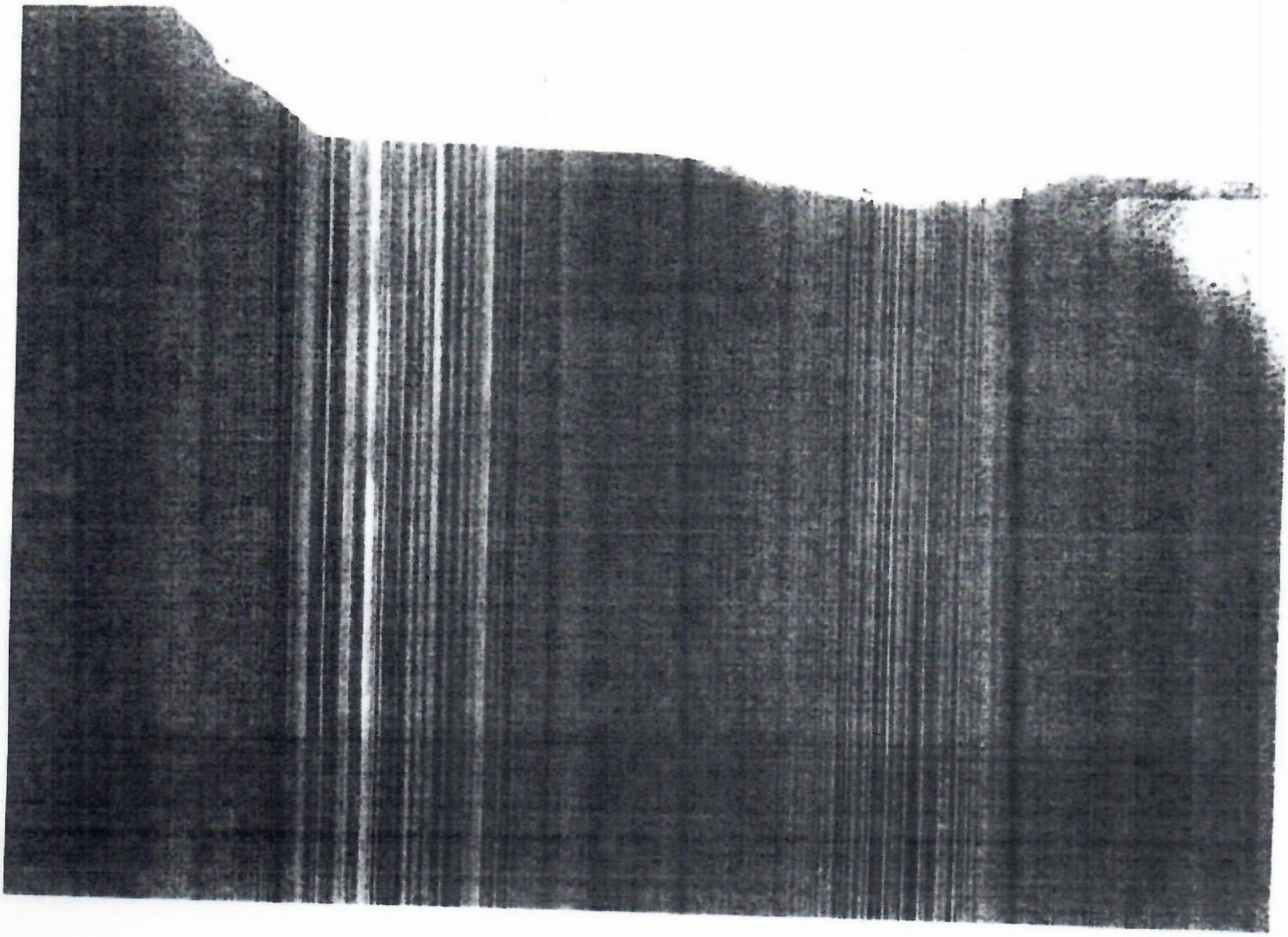
Time 7:15

Person in Charge [REDACTED]

Other staff present [REDACTED]

Time for Evacuation 3 min 1 sec

Brief description of what was involved



[REDACTED]

Employees go to fire, Fire employees
and getting out of bed in

for the first time, Fire, so

part of in the past her out back
side door. From in hallway

gently fire, Fire all - amb. p's

and out. First time they were with

in living room. When employee was

getting resident out of hospital

Don't put her in there if possible

for out of house.

All Ambulance understood as they

was rushing to the out of building

Admission station in the Ambulance

said they clearly understood to

exit building when Fire is around

Admission station again and they

said they still understood to

get out of case of fire.

L!

Dials Family Care
1685 Canal Rd.
Pembroke N.C. 23372

[REDACTED] Employee at Dials Family Care
understands the policy and the procedures due to using a fire
extinguisher due to a fire. Incase of a fire I understand all procedures
to perform in getting my patients out the building. If I am not
comfortable at any given time with the policies and procedures I
[REDACTED] will let office staff be notified as soon as possible.
Incase there is a fire at any given time there is office staff on property
24/7 with assisting with the help of getting patients out the building.
Office staff and numbers are provided below:

[REDACTED]



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

Certified Mail and Electronic Mail
7018-0040-0000-2246-0277

August 19, 2019

Bobbie Dial, Executive Officer
Dial's Family Care, Inc., Licensee
Dial's Family Care Home #10
P.O. Box 4134
Pembroke, N.C. 28372

email address: dialfamily2478@att.net

**Re: Follow-up Survey completed August 02, 2019 (2B5T12)
Unabated Type B Violations**

**Facility: Dial's Family Care Home #10
Licensure Number: FCL-078-079
County: Robeson**

Dear Mr. Dial:

Thank you for the cooperation and courtesy extended during the follow up survey completed August 19, 2019 by staff with the Adult Care Licensure Section and Robeson County Department of Social Services.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

The Type A1 violation in the rule areas of **10A NCAC 13G .0909 Resident Rights** and **G.S. § 131D-21 Resident Rights** was abated as of the correction date, June 30, 2019. Information regarding any penalty recommendation and imposition for the violations identified on the survey completed May 31, 2019 will be mailed separately.

The Type B Violations in the rule areas of **10A NCAC 13G .0902(b) Health Care**, **10A NCAC 13G .0904(e)(4) Nutrition and Food Service** was abated as of the correction date, July 15, 2019. Therefore penalties will not be recommended.

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www.ncdhhs.gov/dhsr/ • TEL: 919-855-3765 • FAX: 919-733-9379

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Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Unabated Type B Violations

- Unabated Type B Violations are cited for **10A NCAC 13G .0302(b) Design And Construction, 10A NCAC 13G .0601(d) Management and Other Staff, and G.S. § 131D-21 Resident Rights.**
- A correction date of August 14, 2019 has been provided.
- Information regarding any penalty recommendation and imposition for the violations will be mailed to you separately.

As set forth in G.S. § 131D-34 where a facility has failed to correct a Type B Violation within the time specified for correction, the Department shall assess the facility a civil penalty in the amount of up to four hundred dollars (\$400.00) for each day that the violation continues beyond the date specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is **SIGNED AND DATED** or it will not be accepted. A response to the plan of correction will be sent **ONLY** if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **September 10, 2019**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
ADULT CARE LICENSURE SECTION**

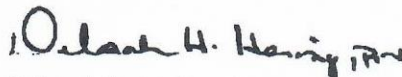
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determination) along with any supporting documentation must be sent and postmarked by **September 10, 2019**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: <http://www.ncdhhs.gov/dhsr/acls/idr.html>.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 910-260-0364. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,



Deborah H. Hering, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Connie Oxendine, Program Administrator, Robeson County Department of Social Services
Fennie Oxendine, Supervisor, Robeson County Department of Social Services
Alfreida Brooks, Administrator w/enclosures (included in certified mail # 7018-0040-0000-2246-0277)
Tamara Talbot, Team Supervisor, East 6 Region, Adult Care Licensure Section
Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: <http://www2.ncdhhs.gov/dhsr/customerservice.html>
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER FCL078079	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/2/2019
NAME OF FACILITY DIAL'S FAMILY CARE HOME #10		STREET ADDRESS, CITY, STATE, ZIP CODE 70 CARE DRIVE PEMBROKE, NC 28372

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form)

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix C0246 Reg. # 10A NCAC 13G .0902(b) LSC	Correction Completed 07/15/2019	ID Prefix C0284 Reg. # 10A NCAC 13G .0904(e) (4) LSC	Correction Completed 07/15/2019	ID Prefix C0311 Reg. # 10A NCAC 13G .0909 LSC	Correction Completed 06/30/2019
ID Prefix C0914 Reg. # G S 131D-21(4) LSC	Correction Completed 06/30/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 08/19/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/31/2019		☒ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☒ YES ☐ NO		

Typo A1 Violation

C311

- The facility manager did provide training on proper use of the pager left with the staff identified in the citation. Employees had been trained and validated shortly after being hired. The next effective 6/1/19 and will remain on going until area is back into compliance.
- This staff person was given additional training pager left training and was validated again on June 3, 2019 ^{personnel} and documentation was placed in ~~personnel~~ ^{personnel} file. The next effective 6/3/19 and will remain on going until area is back into compliance.

C 284 Nutrition and Food Service

The staff were trained received training on 6/3/19 regarding proper assessing resident # I will receive proper therapeutic diet as ordered by physician. Training of staff can be given at facility. The unit will be effective 7/3/19 and will remain on going until the area is back into compliance.

C 022 Design / Construction

The designer did add one additional staff to float between (2) facilities to check on residents and to assist with their needs if needed. However during the follow up construction survey the designer did hire one staff for this facility to work the hours between 10pm - 6am and will be effective 7/15/19 and will remain on going until the area is back into compliance.

C191 Management of Other staff

The facility did have an extra staff person to work (2) facilities between the hours 10 pm - 6 AM effective 6/1/19 and will remain on going until the area is back in compliance. However, on 2/2/19 staff was hired full time to work 24 hours per day 7 days per week for each facility.

C246 - Healthcare

- (1) The primary physician for resident #4 was contacted regarding swallowing issues and the physician changed resident #4 diet to chopped food. The effective July 15th and will be on going.
- (2) Credit area is back into compliance.
- (3) Family of Resident #4 was contacted and family reported swallowing best secondary to resident's age. This is documented and can be found in resident's #4 chart. This is effective 7/15/19 and will be on going until area is back into compliance.