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ADULT CARE LICENSURE SECTION
RALEIGH

Division of Hea th Service Regulation

STATEMENT OF DE ICIENCIES AND PLAN OF COR IECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051038	A. BUILDING: _____ B. WING _____	09/11/2019

NAME OF PROVID, R OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULTIMATE FAM. Y CARE HOME	817 SOUTH SECOND STREET SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initi · Comments The Adult Care Licensure Section conducted an ann. al survey and complaint investigation on Sep ember 10-11, 2019.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exi 10A NCAC 13G .0312 Outside Entrance and Exi (g) n homes with at least one resident who is det mined by a physician or is otherwise known to b disoriented or a wanderer, each exit door for sident use shall be equipped with a sou ding device that is activated when the door is ope ied. The sound shall be of sufficient volume tha it can be heard by staff. If a central system of r mote sounding devices is provided, the con ol panel for the system shall be located in the bedroom of the person on call, the office area or l a location accessible only to staff authorized by ie administrator to operate the control panel. Thi Rule is not met as evidenced by: Ba ed on observations, interviews, and record rev ews, the facility failed to assure a sounding dev ce was activated on 3 of 3 exit doors to alert sta when 2 of 3 sampled residents documented as eing intermittently disoriented (Residents #1 an #3) exited the facility. Th findings are: Ob ervation, upon entrance to the facility, on 09 0/19 at 9:15am revealed the kitchen door wa opened and there was no sounding device he d when the when the glass storm door was op ied. Ob ervation of the exit door next to the laundry	C 069	Door alarms were installed on all the exit doors in the ongoing facility. The supervisor in charge will check quarterly to ensure that the alarms are Operational @ all times. Staff were trained to report any change in residents orientation Status to ensure that adequate Safety measures	9/30/19

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LABORATORY DIRE TOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lillian Okoro-Frum
TITLE: Administrator
(X6) DATE: 10/22/19

STATE FORM 6899 EV8C11 If continuation sheet 1 of 12

Reviewed and accepted with addendum on 10/28/19.
N. Ford, RN Licensure Consultant

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C 069	Cor nued From page 1 roo on 09/10/19 during the initial tour between 10:( )am and 10:30am revealed there was no aud le sounding devices when the door was ope ed. Obs rvation of the front exit door close to Res dent #1's bedroom on 09/10/19 at 1:45pm revi .led there was no audible sounding devices whe I the door was opened. 1. I eview of Resident #1's current FL-2 dated 05/ 3/19 revealed: -Dia noses included hypertension, diabetes, sch oaffective disorder, bipolar type, hyp rlipidemia, and diabetic neuropathy. -Th e was documentation the resident was inte nittently disoriented. Rev aw of a guardianship document in Resident #1's record revealed: -Re ident #1 was adjucated incompetent. -A c unty Department of Social Services was app inted as guardian of the person. Rev aw of the Resident Register for Resident #1 (sig ed but not dated) revealed: -Th resident was forgetful and needed rem nders. -Th resident required assistance for orientation to ti ie and place. Rev aw of Resident #1's Care Plan dated 12/ 3/18 revealed the resident was assessed as forg tful and needing reminders. Rev aw of the most recent licensed health pro: ssional support evaluation dated 08/10/19 revc aled Resident #1 continued to require per dic redirection.	C 069	are adhered to. Administrator/SIC or designated staff will ensure that residents mental status are well documented on the FL-2. The Administrator/SIC or designated staff will check for compliance quarterly during paperwork review.	

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C 069	Continued From page 2 Interview with the Resident Care Coordinator/Supervisor (RCC/Supervisor) on 09/10/19 at 12:10pm revealed: -There were no audible alarms on the exit doors at the facility. -There were no residents at the facility who were known to be disoriented. Second interview with the RCC/Supervisor on 09/10/19 at 1:45pm revealed: -She thought she had looked at the section of Resident #1's FL-2 that listed the resident as intermittently disoriented but mistook that section for indicating the resident's level of toileting function. -She used to check off on the FL-2 that a resident was disoriented if the resident was confused. -She thought the primary care provider completed the "Patient Information" section of the FL-2. Interview with the Administrator on 09/10/19 at 2:10pm revealed: -She was aware of the rule about "constantly disoriented or wanderers" requiring a sounding device on the exit doors. -There were sections on the FL-2 that provided information. -The facility used the physician orders and FL-2 to formulate a plan of care for the residents. Attempted telephone interview with Resident #1's primary care provider on 09/10/19 at 2:50pm was unsuccessful. Refer to the interview with the RCC/Supervisor on 09/10/19 at 1:45pm. Refer to the interview with the Administrator on 09/10/19 at 2:10pm.	C 069	Addendum as per telephone Conversation with Ms. Lillian Okoro-Azuma, Administration on 10/28/19 at 11:36 am: - The live-in staff / direct care staff will check exit door alarms on a daily basis and will report any changes in the alarm system to the Supervisor daily. — H. Forte, Rn Licensure Consultant	

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C 069	Continued From page 3 2. Review of Resident #3's current FL-2 dated 04/3/19 revealed: -Diagnoses included bipolar disorder, leukopenia, and schizoaffective disorder. -There was documentation the resident was intermittently disoriented. Refer to the interview with the RCC/Supervisor on 09/10/19 at 1:45pm. Refer to the interview with the Administrator on 09/10/19 at 2:10pm. Interview with the RCC/Supervisor on 09/10/19 at 1:45 pm revealed: -She could not recall but remembered the facility having alarms around 2 years ago. -Two years ago, alarms would alert when front and back door were being used. -The facility did not have any residents who had wandering behaviors. -She was keeping an eye on the residents. -No one used the front door. -She recalled wiring and battery issues with the previous alarm. -The alarm was loud and waking the residents at night. -She reported the alarm being loud and waking the residents up at night. -The door alarms were checked by the fire marshal because they were going off, and that was the last time she remembered hearing the door alarm sounding device. -She was not aware there was a rule requiring the facility to have a sounding device on the doors if there were residents who were disoriented. Interview with the Administrator on 09/10/19 at 2:10pm revealed: -There were no alarms on the exit doors.	C 069		

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C 069	Continued From page 4 -If the facility had wanderers, then the alarms would be used. -There were no reports of residents walking out of the facility. -She would only consider getting door alarms if she received consistent reports of wandering from staff. -If safety was questionable then she would consider using alarms. -She was aware of the rule about "constantly disoriented or wanderers" requiring a sounding device on the exit doors. -There were sections on the FL-2 that provided information. -The facility used the physician orders and FL-2 to formulate a plan of care for the residents.	C 069		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. If the only staff person on site has been deemed physically incapable of performing these procedures by a licensed physician, that person is exempt from the training.	C 176	All Employee CPR is up to date 9/11/19 Administrator/designated staff will be responsible for checking all staff CPR records on quarterly basis to ensure compliance.	1

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C 176	Cor inued From page 5 Thi Rule is not met as evidenced by: TYI E B VIOLATION Bas d on observations, record reviews and inte views, the facility failed to assure at least one staf member was on duty who had training within the ast 24 months in Cardio-Pulmonary Res iscitation (CPR). The findings are: 1. F eview of Staff B's personnel record revealed: -St f B was hired 03/20/19 as the main live in staf -Th re was no documentation Staff B had com pleted CPR training within the last 24 mon ths. -Th re was documentation of completion of CPR trai ng on 01/03/17. Atte npted telephone interview with Staff B on 09/ 1/19 at 1:43 pm was unsuccessful. Inte view with the Administrator on 09/10/19 at 2:3 pm revealed: -St f records were checked every quarter to ens re compliance. -Re ords were reviewed two weeks during the pro ess of thinning personnel charts and during tha ime, she identified some of the information mis ing. -Th t was when she realized Staff B did not have cur nt CPR certification. -Th CPR training was only a renewal and the kno ledge remained, although the CPR had exp ed. -In n emergency, she expected staff to use the kno ledge they had to address the emergency and call emergency management and sup rvisory staff. 2. eview of the Resident Care	C 176	Addendum as per telephone Conversation with Ms. Lillian Okoro-Nzema, Administrator on 10/28/19 at 1136 pm: - CPR training was conducted/ completed on 9/11/19 for staff employed at the facility. - The Administrator/designated staff will create a checklist of staff training expiration dates and update quarterly. - The Administrator/designated staff will continue to be responsible for checking all staffing records on a quarterly basis to ensure training compliance. - Date of correction will be 9/12/19. Ms. Forte, Licensure Consultant	

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C 176	Cor inued From page 6 Coc dinator/Supervisor (Staff A) personnel record rev aled: -Th e was a hire date of 05/20/16. -Th e was documentation of successfully con leting a CPR course on 08/29/17 which was val for 2 years. -Th e was no documentation Staff A had con leted CPR training within the last 24 mo hs. Inte iew with Staff A on 09/10/19 at 9:30am rev aled: -Sh was a supervisor and medication aide for the cility. -Sh was the relief live-in staff for the facility. -Sh was currently the live-in staff on duty for the facil y. -Th "main" live-in staff stayed in the facility for thre weeks and then off one week. -Six esidents lived in the facility. -Fiv residents were at a day program. -Th e was one resident at the facility today. -Th facility was in the process of getting the resi ent, who was at the facility today, in to a day pro am. Inte iew with the Administrator on 09/10/19 at 3:30 m revealed: -Sh recently found out Staff A's CPR had exp d. -Th facility had planned for a CPR class to be con cted on 09/06/19 but due to weather con ions, the trainer was not able to come to the facil y. -The facility had rescheduled the CPR class for 09/0 /19 but the trainer was not able to come to the f cility to conduct the CPR class. Inter iew with Staff A on 09/10/19 at 3:35pm reve ed:	C 176		

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C 176	Co inued From page 7 -Sh found out her CPR had expired one day last wee ; when she and facility staff were transferring per onnel records from folders to notebooks. -Sh had not been told prior to last week that her CPI training needed renewal. Sec nd interview with the Administrator on 09/ /19 at 2:30pm revealed: -Sh checked staff records quarterly. -Sh had reviewed staff personnel records two wee ago. -In an emergency she would have expected staff to u e the knowledge they had to address the eme gency and call emergency management and sup visory staff. The acility failed to assure there was one staff mer ber on duty in the facility at all times who had com leted a course on CPR and choking man gement within the last 24 months. The facil 's failure was detrimental to the health and safe of the resident in the event of an eme gency requiring CPR or management of a chok ng resident. This non-compliance cons tutes a Type B Violation. The acility provided a plan of protection in acco dance with G.S. 131D-34 on 09/10/19 for this olation. COR RECTION DATE FOR THE TYPE B VIOL TION SHALL NOT EXCEED OCTOBER 25, 2 19.	C 176		
C 272	10A CAC 13G .0904(d)(2) Nutrition and Food Serv e 10A I CAC 13G .0904 Nutrition and Food Servi e	C 272		

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C 272	Continued From page 8 (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure snacks were offered or made available to all residents three times a day. The findings are: Review of the facility's posted week three menu revealed: -There were no listed snacks or snack options to be served. -There were no times listed for snacks to be served. Interview with a resident on 09/10/19 at 10:20am revealed: -He got a snack "before dark". -If he asked staff for a snack, the staff would give him a snack. Interview with the Resident Care Coordinator/Supervisor (RCC/Supervisor) on 09/11/19 at 10:30am revealed: -Snacks were made available at 3:00pm-3:20pm when the residents at the day program returned to the facility. -Residents were provided snacks at other times if the residents asked for a snack. -Sometimes after dinner, a resident would ask for a snack. -There was one resident (named) who was typically asked if he wanted a snack after the	C 272	List of Snacks to be served has been displayed close to where the menu is posted Snacks will be made available and offered to residents between meals. All direct care staff has been inserviced to offer residents snacks between meals.	9/11/19 Ongoing

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C 272	Continued From page 9 dinner meal. -There was no specific time of the day that snacks were offered. Observation of a resident on 09/10/19 at 11:45am revealed the RCC/Supervisor served the resident a bag of popcorn and water. Observation of available snacks on 09/10/19 at 3:15pm revealed: -The RCC/S laid individual bags of cheese doodles on the kitchen countertop. -Two of the six residents in the facility took a bag of the snack left on the kitchen countertop. Interview with a second resident on 09/10/19 at 4:20pm revealed: - Snacks were offered twice a day. - Snacks were provided at night time. - Snacks were given after he returned from the day program. Interview with a third resident on 09/10/19 at 4:27pm revealed: -Snacks were given twice a day. -Snacks were given in the evening when he returns from the day program. -Snacks were given at bed time. Interview with a fourth resident on 09/10/19 at 4:30pm revealed: -He got a snack when he returned to the facility from the day program. -He got one snack a day. -He could get a snack if he wanted a snack. Interview with fifth resident on 09/10/19 at 4:36pm revealed: -Snacks were given twice a day. -Snacks were given in the afternoon when he	C 272	SIC will review and update Administrator on monthly basis during staff meeting to ensure compliance Addendum as per telephone conversation with Ms. Lillian Okoro-Kajuma, Administrator on 10/28/19 at 1136 hrs: - Snacks will be made available and offered to residents at least three times per day. - Date of correction will be 9/12/19. - H. Tesh, RN Licensure Consultant	

ULTIMATE FAMILY CARE HOME INC.
817 SOUTH SECOND STREET
SMITHFIELD, NC 27577
Phone: (919) 880-3144. Fax: (919) 550-2163

October 22, 2019

Dear Ms. Forte,

Please find attached plan of correction on the annual and complaint investigation completed on September 11, 2019 on FCL 051-038.
For more questions or any clarifications please call 919-880-3144

Sincerely,

10/22/19

Lillian Okoro-Ezuma

Administrator UFCHomes