Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____ RECEIVED	R-C 09/11/2019

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

NOV 21 2019
ADULT CARE LICENSURE SECTION
RALEIGH

(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) COMPLET. DATE
{C 000}	Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services conducted a follow up survey and complaint investigation on 09/11/2019. The Robeson County Department of Social Services initiated the complaint investigation on 08/26/19.	{C 000}		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to maintain a hazard-free environment related to an unsecured oxygen cylinder, a broken glass window pane, unstable shelves in resident room #6, and a protruding latch plate on the front door entrance. The findings are: 1. Observation of resident room #2 on 09/11/19 at 10:05am revealed: -There was a small reach-in closet with the door closed. -There was a tall, 4 foot (ft) oxygen (O2) cylinder sitting on the floor unsecured without a rack or	C 078	Facility talk to there Staff and explained to them that All (O2) must	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

This plan of Correction has been Received/ acknowledged. (Refer to pag 12 for stamped date received on 01/03/20) Dilli 01/24/20

The Plan of Correction was reviewed, not accepted DN 12/20/19

Owner Signed and emailed Page(1) from a prior survey on 01/17/20 Telephone conference with Alfrida Brooks/Owner, Kim Hunt/Administrator, Both agreed to process without Page(1) received 01/03/20. See Addendum Page 12 For Stamp date received. DN 1/24

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C 078	Continued From page 1 crate positioned in the right front corner of the closet. Interview with a live-in personal care aide (PCA) on 09/11/19 at 10:15am revealed: -The large O2 cylinder in resident room #2 was delivered around 09/04/19 because of the storm. -She was not working the day the O2 cylinder was delivered. -She saw the O2 cylinder in the closet when she returned to work but did not know who put the cylinder in the closet. -She would call the durable medical equipment (DME) provider now to get a rack or crate to have the O2 cylinder secured in resident room #2. Based on observations, interviews, and record review, it was determined the resident assigned to resident room #2 was not interviewable. Observation of resident room #3 on 09/11/19 at 10:08 revealed: -There was a small reach-in closet with the door closed. -There were 2 medium and one large sized O2 cylinders stored in an O2 rack in the front right corner of the closet. Interview with a second live-in PCA on 09/11/19 at 12:50pm revealed: -A DME provider representative delivered a large O2 cylinder for a resident the day before (09/04/19) Hurricane Dorian. -The DME delivery person placed an unsecured O2 cylinder in a resident's closet when delivered. -When the O2 cylinder was delivered the DME provider did not bring a O2 storage rack to secure the O2 cylinder. -The DME representative was to bring the O2 cylinder storage rack back, but never did.	C 078	be positioned in a right Rank and that O2 has to be placed in an open area.	9-11-19

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C 078	Continued From page 2 -She had not reported the unsecured O2 cylinder to other staff or management of the facility. -She had not reported there was not a storage rack for the large O2 cylinder to other staff or management of the facility. -She had not contacted the DME provider for an O2 cylinder storage rack since it was delivered on 09/04/19. -She was not concerned about knocking over the O2 cylinder because she was not going to bump into the cylinder. -She did not know O2 cylinders could not be stored in a closet. -The business office manager (BOM) may have checked storage of O2 cylinders in the facility twice in the past year. -No one had checked behind her to see how the O2 cylinders were stored since delivered. -She had never received training since being employed at the facility in 2013 on how to properly store O2 cylinders. Telephone interview with the facility's lead training officer with the durable medical equipment (DME) provider on 09/11/19 at 10:32am revealed: -O2 cylinders should not be stored in small closets with the door closed. -Small, non-ventilated areas were not safe to store O2 because non-ventilated spaces such as closets could become fully engulfed in a fire because of the O2 in the cylinder before staff would know anything about it. -O2 made fire burn "more intensely". -O2 should never be stored in a small non-ventilated area because oxygen can accumulate around the immediate surroundings in confined spaces and become a fire hazard. -A 4 ft O2 cylinder was delivered to the facility last week (week of 09/02/19). -The DME delivery person would not have placed	C 078	Also Facility did Contact DME and explain to them the importance of them coming out and @ Checklist All facility to assure that O2 is placed Corrected.	9-11-19

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C 078	Continued From page 3 the O2 cylinder in the closet unless told to do so and the delivery person would have told staff to keep the door opened to the closet. -There should have been a "foot" on the 4 ft. O2 cylinder and not stored directly on the floor. (A foot is a rack that stabilizes the O2 cylinder to prevent the cylinder from tipping over). -If there was no stabilization device on the 4 ft O2 cylinder the staff at the facility should have called the DME provider and a stabilization device could have been delivered immediately. -The DME provider was available 24 hours a day seven days a week. Telephone interview with a second representative with the DME provider on 09/11/19 at 10:40am revealed: -The stabilization of oxygen cylinders was important and an oxygen cylinder without a rack or crate for stabilization was not safe. -An O2 cylinder had 2000 lbs of oxygen/pressure per square inch. -If an O2 cylinder was accidentally knocked over it would "take off like a torpedo" and knock out walls, would remove arms, legs or a torso if a person was standing in the path of the cylinder before it stopped. Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 09/11/19 at 10:29am revealed: -He knew an O2 cylinder was delivered to the facility last week for the resident assigned to resident room #2 in order to prepare for the pending hurricane. -He told the DME provider's office to make sure the O2 cylinder was in racks. -He saw the DME provider when they pulled up last week and delivered the O2 cylinder and even sent the driver a text to make sure the cylinder	C 078		

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C 078	Continued From page 4 was placed in a rack or crate. -He did not check to make sure the O2 was secured in a rack or crate after it was delivered because he should not have to go behind the DME provider he had already made a phone call and sent a text to the DME provider. -He was not aware O2 cylinders had been placed in the closets in resident room #2 or #3. -Back-up O2 cylinders were not routinely stored in closed closets. -He thought it was not good to have the O2 cylinders in the residents' closets because when staff needed the O2 cylinders they would be out of sight and staff might not realize the O2 tanks were available or forget about them because they were not stored in sight of staff. -O2 cylinders were supposed to be stored in the resident rooms in a rack or crate but not in closets. -He was not aware O2 cylinders should not be stored in a small non-ventilated room. Interview with the Owner on 09/11/19 at 10:51am revealed: -Staff were aware that all O2 cylinders needed to be stored in a rack or crate. -She would have expected the SIC/MA to have checked the O2 cylinder in resident #2's room after it was delivered last week to make sure the O2 cylinder was secured in a stand or crate. Telephone interview with the Owner on 09/11/19 at 3:53pm revealed: -She knew O2 cylinders always needed to be secured in an O2 cylinder storage rack. -She did not know O2 cylinders could not be store in a closet until today, (09/11/19). -Staff had not been trained on how to properly store O2 cylinders. -She expected the DME provider to properly store	C 078	All Staff is aware and meet C SIC / Med-Tech to assure that it has been taken care of.	

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C 078	Continued From page 5 O2 cylinders when delivered. -She did not know there was an unsecured O2 cylinder in the facility. -No one performed O2 cylinder checks to be certain they were secured properly. -The DME provider delivered the O2 cylinders when Hurricane Dorian was coming and did not secure them properly. -She expected the DME company to have properly stored the O2 cylinders when delivered. -"I'd rather not answer that right now" when asked what her expectation was regarding staff properly securing O2 cylinders. A second interview with the Owner on 09/11/19 at 5:15pm revealed she needed to be educated on O2 by the DME company to be certain she knew all the safety needs for oxygen. Refer to a second interview with the Owner on 09/11/19 at 5:15pm. 2. Observation of resident room #6 on 09/11/19 at 11:50am revealed: -There was a bathroom door on the far-right side of the room. -There was a closet door on the near right side of the room behind the room door. -Over each door was a flat, white colored wood type shelf approximately 4-foot long. -The shelf over the bathroom door was secured by a metal bracket on the upper right and left side of the door frame. -The top of each bracket had one screw hole each to secure the shelves to the brackets. -The screws in each bracket were not flush and backed out by approximately 1/4th of an inch each leaving the shelf unsecured and could be moved up and down from the bracket. -On the shelf positioned over the bathroom door,	C 078	-All Staff new hire and existing staff will be taught the importance of O2.	

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C 078	Continued From page 6 there was a white Styrofoam cooler that was approximately five pounds (lbs), a five-gallon bucket, and two plastic containers with lids that were approximately 2 gallon size. -The left side of the shelf over the closet door was secured with one metal bracket and one screw that was not flush and backed out by approximately 1/4th inch which left the shelf unsecured and could be lifted up and down. The left side of the shelf could be lifted easily and completely off the left side of the room entrance door frame. -On top of the shelf was a box that was approximately 3 lbs, two smaller plastic containers, and two hospital basins that contained items. Interview with the "handy-man" for the facility on 09/11/19 at 12:10pm revealed: -He was just told by the Owner to take down the shelves in the resident room #6 today, (09/11/19). -The shelves had been over room #6's closet and bathroom door since he began working in the facility one year ago. -Both shelves were loose and could be moved up and down. -The shelf over the closet door needed a bracket on the right side for support to make it stable instead of resting unsecured on top of the door frame. -The screws were not all the way in the shelves because the screws were too long. -The right and left shelves would raise up approximately ½" when pushed up. -The right side of the shelf over the closet door would raise completely when pushed up because it was not secured. -The shelf over the bathroom and closet door were at risk of falling from the wall because both were loose and not secured tightly and were	C 078	WAS removed the same day state was out.	9/11/19

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C 078	Continued From page 7 unstable. Interview with a live-in personal care aide (PCA) on 09/11/19 at 12:50pm revealed: -The shelves over the bathroom and closet door of resident room #6 had been there for about three to four years. -She thought they belonged to a previous resident who was no longer at the facility. -She did not know who put up the shelves in room #6. -She did not know who put the containers on the shelves. -She thought the containers on the shelves belonged to a resident. -The resident had asked her to get things off the shelves more than six months ago. -She did not know if the shelves were stable or not because she had never touched the shelves. -She had never noticed how the shelves were installed. -She had never noticed screws backing out of the shelves. -The shelves had not fallen in the past. Telephone interview with the Owner on 09/11/19 at 3:53pm revealed: -The shelves in resident room #6 had probably been there more than 10 years. -She did not know who put up the shelves. -She had not noticed the shelves in the room until the beginning of September 2019. -She had not noticed the screws backing out of the shelves. -She always inspected the building every week for cleanliness. -She had never looked at shelving during building inspections. -All facility staff were responsible to inspect shelving and any wall attachments for stability	C 078	Plan to ensure that All Rooms are a SAFE environment as well.	

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C 078	Continued From page 8 and safety. -The shelving had been over looked by her and the staff during the inspections. Interview with the resident assigned to resident room #6 revealed: -The items on the shelves over the bathroom and closet door belonged to him. -The shelving and items had been there a long time. -He could get the items off the shelf by himself if he needed to. -The shelving had never fallen and none of the items had ever fallen off the shelves. Refer to a second interview with the Owner on 09/11/19 at 5:15pm. 3. Observation of an inside window in room #6 on 09/11/19 at 12:10pm revealed there was a gray tape like substance over the top portion of the window approximately 36 inches wide by 12 inches high. Observation of room #6's window from the outside of the building on 09/11/19 at 2:00pm revealed: -There were seven strips of a gray tape like substance covering the left upper part of the window approximately 9 inches long by 12 inches tall. -One of the seven strips of tape was peeling up from the bottom left of the window. -There was tape on the inside of the top window extending from the left to the right side approximately 36 inches long. Interview with the resident assigned to resident room #6 revealed he did not know how long or how the glass window pane had been broken in	C 078		

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C 078	Continued From page 9 his room Interview with the "handy-man" on 09/11/19 at 12:10pm revealed: -He did not know how long the window had been broken. -He did not know how the window was broken. -The personal care aide (PCA) told him two - three days ago he needed to replace the window because it was broken. -The Owner had never mentioned the broken window to him. -The Owner would probably have a window repair person to replace the broken window because they were specialized in broken windows. Interview with the live-in PCA on 09/11/19 at 12:50pm revealed: -The window in room #6 was a double pane window. -Only the outside of the window was broken. -The window had been broken for years. -She did not know how the window was broken. -She did not know who taped the broken window. -She had told the Owner and the Business Office Manager (BOM) about two months ago the window was broken. -She last told the BOM the window was broken two weeks ago and she said, "OK". -There were no water leaks or wind damage to the window during Hurricane Dorian. -There had not been any injures with the broken glass window pane. Telephone interview with the Owner on 09/11/19 at 3:53pm revealed: -Construction had inspected the window in room #6 during their survey on 09/04/19. -She did not know about the broken window until construction pointed it out to her.	C 078		

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C 078	Continued From page 10 -Construction had given her until November 2019 to replace the window. -She did not know how long the window had been broken. -The broken window had to have happened over the summer of 2019. -She did not know who taped the broken window. -She did not know when the broken window was taped. -All the staff were responsible to inspect the buildings. -There was no one responsible for inspecting the windows for damages or hazards. -No one had reported the broken window to her. -She had not contacted anyone to repair or replace the broken window. -She did not think the broken window was a hazard to residents. Refer to a second interview with the Owner on 09/11/19 at 5:15pm. 4. Observation of the front door on 09/11/19 at 12:07pm revealed: -The inner door latch compartment was not flush with the door. -The plate surrounding the door latch protruded from the door. -There was a screw at the top and bottom of the plate. -The screws were not flush with the door. -The door latch and plate rubbed against skin when bumping into the door, creating a hazard. A second observation of the front door latch and plate on 09/11/19 at 4:14pm revealed: -The inner door latch compartment protruded ¼ inch from the door. -The plate surrounding the door latch was two inches long.	C 078	Plan to ensure that door will be fixed. (Handle)	

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C 078	Continued From page 11 -The plate protruded ¼ inch from the door. -The upper and lower screw heads protruded a little over ¼ inch from the door. Observation of the front door on 09/11/19 at 4:43pm revealed: -The handy man tightened the upper and lower screws on the plate that surrounds the door latch compartment of the front door. -As the screws were tightening the door plate curved in at the top and the bottom where the screws were. -The middle of the door plate remained protruding from the door. Interview with the personal care aide (PCA) on 09/11/19 at 12:50pm revealed: -The door knob was changed 2 weeks ago by an outside maintenance person -The plate surrounding the door latch had been sticking out since the door knob was changed. -The Business Office Manager (BOM) had called the outside maintenance person to come back to the facility to repair it because the plate was sticking out and was not flush with the door. -She didn't not know when the BOM had called maintenance to repair the plate. -There had not been any injuries from the door plate sticking out from the door. Telephone interview with the Owner on 09/11/19 at 3:53pm revealed: -The door knob was changed on 09/04/19. -The BOM had called and told her when maintenance changed out the door knob, the door plate was not flush with the door. -She noticed the door plate was not flush with the door today. -She did not think the door plate not being flush with the door was a hazard to residents.	C 078	Added - 12-23-19 A. Brown Plan to esure that SIC and owner will moinoter the Facility weekly to esure that there will not be any hazards will clks resi dents Rooms will clk All Construction sites to ensure the safety of All residents. Weekly and will Ask employees weekly to esure that they are in a safe environment.	

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C 078	Continued From page 12 Interview with the "handy-man" on 09/11/19 at 4:40pm revealed: -He did not replace the door knob. -An outside contractor had replaced the door knob two to three weeks ago. -He thought the door plate protruded from the door because the internal door latch compartment was too long for the door. A second interview with the Owner on 09/11/19 at 5:15pm revealed: -She had noticed the front door plate protruding from the door one week ago. -She did not think the protruding door latch was a hazard because it could not harm the residents even though it was not flush with the door. Refer to a second interview with the Owner on 09/11/19 at 5:15pm. A second interview with the Owner on 09/11/19 at 5:15pm revealed if there were problems with the facility or hazards the live-in personal care aides (PCA's) would report to her, the Supervisor-in-Charge/medication aide (SIC/MA), or the Business Office Manager (BOM). The facility failed to ensure portable oxygen cylinders were stored securely in a well ventilated area creating a potential for an unsecured cylinder to fall and/or be knocked over, damaging the valve, and rapidly releasing the high-pressure gas from the cylinder, potentially causing explosions in the facility. The facility's failure was detrimental to the health and safety of the residents which constitutes a Type B Violation. A Plan of Protection (POP) was submitted by the	C 078		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078079	A. BUILDING: _____ B. WING _____	R-C 09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 078	Continued From page 13 facility in accordance with G.S. 131D-34 on 09/11/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2019.	C 078		
{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 housekeeping and furnishings. The findings are: Based on observations and interviews, the facility failed to maintain a hazard-free environment related to an unsecured oxygen cylinder, a broken glass window pane, unstable shelves in resident room #6, and a protruding latch plate on the front door entrance. [Refer to Tag 0078 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings(Type B Violation)].	{C 912}	- Has been put in place.	9-11-19