STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on April 20-21, 2021.	C 000		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure blood pressure (BP) checks were implemented and documented as ordered for 1 of 3 sampled residents with orders for daily BP checks (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 09/02/20 revealed: -Diagnoses included essential hypertension schizoaffective disorder, bipolar disorder, intellectual disability, vitamin D deficiency, cholelithiasis, obesity, dyslipidemia, and multiple right renal cystis. -There was an order for daily blood pressure (BP) monitoring. Review of Resident #2's February, March, and April 2021 medication administration record (MAR) revealed there were no entries for daily	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 249	Continued From page 1	C 249		

BPs and there was no documentation of BPs for Resident #2.
-There was no documentation of refusals of BPs for Resident #2.

Review of Resident #2's record revealed there was no documentation of daily BPs for Resident #2.

Based on observations, and interviews, Resident #2 attended a local community day program Monday through Friday.

Telephone interview with a nurse at Resident #2's primary care provider's (PCP) office on 04/21/21 at 3:17pm revealed:
-Resident #2's FL-2 dated 09/02/20 was not completed by Resident #2's PCP.
-Resident #2 had a diagnosis of hypertension but the current PCP had not recommended daily BPs because Resident #2's BP was not abnormal.
-Resident #2 took amlodipine and metoprolol to treat hypertension.

Interview with the Supervisor in Charge (SIC) on 04/21/21 at 11:28am revealed:
-Resident #2's FL-2 was reviewed by him.
-He did not see Resident #2's order for daily BPs and he did not monitor Resident #2's BP daily.

Interview with the Administrator on 04/21/21 at 12:45pm revealed:
-She telephoned staff last week on 04/15/21 and told them to review residents' FL-2s again to ensure no orders were missed.
-She expected staff to document residents' BPs on a form she provided for BP readings, but at this facility staff documented BPs on the MARs.
-She did not know Resident #2 had daily BPs order on his current FL-2 and his BPs were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 249	Continued From page 2 obtained daily. -She reviewed BPs when she visited the facility three times per week but did not know Resident #2 had an order for daily BPs. -She was responsible for ensuring residents' blood pressure was checked and documented.	C 249		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) A family care home shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers, up to and including	C 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 252	Continued From page 3 a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections as stated in Rule .1004(q) of this Subchapter; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph (14) of this Paragraph); (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or	C 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 252	Continued From page 4 (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure licensed health professional support (LHPS) evaluations were completed the first 30 days upon admission and at least quarterly thereafter for 2 of 3 sampled residents to include a resident admitted on 09/06/20 (#2) without an initial LHPS evaluation and another resident with a LHPS task for fingerstick blood sugar (FSBS) (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 09/02/20 revealed: -Diagnoses included schizoaffective disorder, bipolar disorder, intellectual disability, essential hypertension, vitamin D deficiency, cholelithiasis, obesity, dyslipidemia, and multiple right renal cystis. -There was an order for physical therapy twice weekly for three weeks. Review of Resident #2's LHPS evaluations revealed there were no LHPS evaluations for review. Attempted interview with Resident #2 on 04/20/21 at 9:20am and on 04/21/21 at 9:10am was unsuccessful. Interview with the Supervisor in Charge (SIC) on 04/20/21 at 8:48am revealed Resident #2 was admitted in 2020 and he did not participate in the	C 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 252	Continued From page 5 completion of residents' LHPS evaluations. Refer to interview with the Administrator on 04/21/21 at 12:45pm. 2. Review of Resident #3's current FL-2 dated 06/12/20 revealed: -Diagnoses included controlled type 2 diabetes mellitus, frequent falls, depression, hypertension, and chronic osteoarthritis. -There was no order for fingerstick blood sugar (FSBS) monitoring. Review of Resident #3's six month physician orders dated 04/01/21 revealed there was an order for FSBS daily, but the orders were not signed by Resident #3's primary care provider (PCP). Review of Resident #3's record revealed there were no licensed health professional support (LHPS) evaluations. Review of Resident #3's February, March and April 2021 medication administration records (MARs) revealed: -There was an entry for FSBS daily, scheduled for 8:00am and a space titled "result". -There was documentation of FSBS results from 02/01/21 to 04/20/21 for 8:00am. -Resident #3's FSBS ranged between 78 to 120. Interview with Resident #3 on 04/21/21 at 11:15am revealed staff obtained his FSBS daily and he took oral medications for the treatment of diabetes. Interview with the Supervisor in Charge (SIC) on 04/20/21 at 8:48am revealed Resident #3 was the only resident who had FSBS ordered daily.	C 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 252	Continued From page 6 Refer to interview with the Administrator on 04/21/21 at 12:45pm. _____ Interview with Administer on 04/21/21 at 12:45pm revealed: -She knew some residents had FSBS ordered by the residents' primary care provider (PCP). -She currently had a LHPS nurse to complete the LHPS evaluations for residents, but she had not seen her in 9 months. -She thought LHPS evaluations were supposed to be completed annually for residents with LHPS tasks. -She knew the LHPS evaluations were not completed because she had not contacted the LHPS nurse due to the global pandemic. -She was responsible for ensuring the LHPS evaluations were completed for residents.	C 252		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 315	Continued From page 7 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facilty failed to ensure 1 of 3 sampled residents (#1) prescribing practitioner was contacted for clarification of medication orders related to a skin moisturizer, a histamine antagonist medication, and a pain medication. 1. Review of Resident #1's current FL-2 dated 06/18/20 revealed diagnoses included rectal pain, hemorrhoids, human immunodeficiency virus (HIV) early onset dementia, and gastro-esophageal reflux disease. a. Review of Resident #1's current FL-2 dated 06/18/20 revealed there was a medication order for ranitidine 300mg daily (a histamine antagonist). Review of Resident #1's February, March and April 2021 medication administration record (MAR) revealed there were no entries for ranitidine 300mg daily. Observation of Resident #1's medications on hand on 04/21/21 at 12:15pm revealed there was no ranitidine available for administration. Review of Resident #1's record revealed Resident #1 did not have a discontinue order for ranitidine. Interview with Resident #1 on 04/21/21 at 9:09am revealed: -He had abdominal discomfort and burning in the past, but his abdomen was improved now. -He did not know if he took any medication now that treated his abdominal discomfort.	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 315	Continued From page 8 Telephone interview with a representative from the facility contracted pharmacy on 04/21/21 at 12:27pm revealed: -The pharmacy did not have an order dated 06/18/20 for ranitidine. -A previous order for ranitidine was discontinued in 2019. -Ranitidine was last dispensed for Resident #1 on 07/16/19. Telephone interview with a nurse at Resident #1's primary care provider's (PCP) office on 04/21/21 at 3:17pm revealed: -Resident #1 had a history of gastro-esophageal reflux disease (GERD), but had no recent complaints of GERD. -At this time, Resident #1's PCP did not have a medication prescribed to treat GERD. -Resident #1 did not have a discontinue order for ranitidine, and ranitidine was not listed on his active medication list. -Resident #1 became a new patient for the PCP in 09/2020 but his PCP had not completed the FL-2 dated 06/18/20. Interview with a Supervisor in Charge (SIC) on 04/21/21 at 11:28am revealed: -He did not know Resident #1 had an order for ranitidine on his FL-2 dated 06/18/20. -He had not received ranitidine to administer to Resident #1. -If he had noticed Resident #1 had an order for ranitidine and he had not received it from the pharmacy, he would have called Resident #1's PCP and the pharmacy. Refer to interview with the SIC on 04/21/21 at 11:28pm. Refer to interview with the Administrator on	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 315	Continued From page 9 04/21/21 at 12:45pm. b. Review of Resident #1's current FL-2 dated 06/18/20 revealed there was a medication order for aspirin 81mg daily (used to reduce fever and mild pain). Review of Resident #1's February, March and April 2021 medication administration record (MAR) revealed there were no entries for aspirin 81mg daily. Observation of Resident #1's medications on hand on 04/21/21 at 12:15pm revealed there was no aspirin available to administer. Review of Resident #1's record revealed Resident #1 did not have a discontinue order for aspirin. Telephone interview with a representative from the facility contracted pharmacy on 04/21/21 at 12:27pm revealed: -There was no order for aspirin on Resident #1's computer profile. -Aspirin was never dispensed for Resident #1 but it was available over the counter. Telephone interview with a nurse at Resident #1's primary care provider's (PCP) office on 04/21/21 at 3:17pm revealed: -Resident #1 was last seen by his PCP on 03/02/21. -Resident #1 did not have aspirin listed on his active medication list. -Resident #1 did not have a discontinue order for aspirin. Interview with a Supervisor in Charge (SIC) on 04/21/21 at 11:28am revealed:	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 315	Continued From page 10 -He did not know Resident #1 had an order for aspirin 81mg on his 06/18/20 FL-2. -Resident #1 did not have a discontinue order for aspirin. Refer to interview with the SIC on 04/21/21 at 11:28pm. Refer to interview with the Administrator on 04/21/21 at 12:45pm. c. Review of Resident #1's current FL-2 dated 06/18/20 revealed there was a medication order for ammonium lactate 12% cream twice daily (a skin moisturizer). Review of Resident #1's February, March and April 2021 medication administration record (MAR) revealed there were no entries for ammonium lactate 12% cream. Observation of Resident #1's medications on hand on 04/21/21 at 12:15pm revealed there was no ammonium lactate cream available to administer. Review of Resident #1's record revealed he did not have a discontinue order for ammonium lactate cream. Telephone interview with a representative from the facility contracted pharmacy on 04/21/21 at 12:27pm revealed: -There was an older order on Resident #1's profile for ammonium lactate dated 10/16/18. -Staff from the facility called the pharmacy in 2019 and stated Resident #1 was no longer prescribed ammonium lactate cream. -A discontinue order was not received for ammonium lactate cream from Resident #1's	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 315	Continued From page 11	C 315		

primary care provider (PCP).
-Ammonium lactate cream was last dispensed in 2019.

Telephone interview with a nurse at Resident #1's PCP office on 04/21/21 at 3:17pm revealed:
-There was no order for ammonium lactate cream on Resident #1's computer profile.
-There was no history of a discontinue order for ammonium lactate cream for Resident #1.

Interview with a Supervisor in Charge (SIC) on 04/21/21 at 11:28am revealed:
-He did not know there was an order on Resident #1's FL-2 dated 06/18/20.
-He would have called the pharmacy and Resident #1's PCP, when the medication was never received from the pharmacy.

Refer to interview with the Administrator on 04/21/21 at 12:45pm.

_____

Interview with a Supervisor in Charge (SIC) on 04/21/21 at 11:28am revealed:
-He reviewed Resident #1's FL-2, but he did not fax it to the pharmacy.
-Resident #1's FL-2 was completed and signed by his previous PCP.
-He did not call Resident #1's PCP concerning these medications.
-He had not called the pharmacy concerning these medications.
-He would have called the PCP and the pharmacy if he had noticed the medications were not delivered from the pharmacy but on the current FL-2.

Interview with the Administrator on 04/21/21 at 3:29pm revealed:
-She and staff reviewed residents' FL-2s and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 315	Continued From page 12 ensured the medications were on the MARs. -She did not know Resident #1 had medications that were ordered on his current FL-2 which were never administered. -Staff were expected to ensure medications ordered by the PCP were received from the pharmacy, placed on residents' MARs and contact the PCP, pharmacy and her if there were any questions.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents related to a steroidal topical medication (#1). The findings are: Review of Resident #1's current FL-2 dated 06/18/20 revealed diagnoses included rectal pain, hemorrhoids, human immunodeficiency virus (HIV) early onset dementia, and gastro-esophageal reflux disease.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 13 Review of Resident #1's current FL-2 dated 06/18/20 revealed there was a medication order for triamcinolone cream 0.025% apply twice daily (a steroidal cream). Review of Resident #1's record revealed Resident #1 did not have a discontinue order for triamcinolone cream. Review of Resident #1's February, March and April 2021 medication administration record (MAR) revealed there were no entries for triamcinolone cream. Observation of Resident #1's medications on hand on 04/21/21 at 12:15pm revealed there was no triamcinolone cream available to administer. Interview with Resident #1 on 04/21/21 at 9:09am revealed he did not know the names of his medications, but he used a topical medication for his skin. Telephone interview with a representative from the facility contracted pharmacy on 04/21/21 at 12:27pm revealed: -The pharmacy did not have Resident #1's FL-2 dated 06/18/20. -Resident #1 had an old prescription for triamcinolone from 2018. -The order was inactive in the computer system. -Triamcinolone cream was last dispensed for Resident #1 on 12/18/18. Telephone interview with a nurse at Resident #1's primary care provider's (PCP) office on 04/21/21 at 3:17pm revealed: -Resident #1 became a client of his PCP on 09/2020. -The office had a copy of Resident #1's FL-2 on	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 14 record. -Resident #1's PCP had not discontinued triamcinolone cream, it was not listed as an active medication for Rsident #1. -Resident #1 had analapram hydrocortisone cream, terbinafine cream and nystatin powder ordered for his skin conditions. Interview with a Supervisor in Charge (SIC) on 04/21/21 at 11:28am revealed: -He reviewed Resident #1's FL-2 but he had not transcribed the triamcinolone onto Resident #1's MARs. -He thought the triamcinolone was discontinued but he did not have a discontinue order for Resident #1's triamcinolone cream. -He had not faxed Resident #1's FL-2 to the pharmacy and was not aware the pharmacy did not have the 06/18/20 order for triamcinolone. Interview with the Administrator on 04/21/21 at 3:29pm revealed: -She and staff reviewed residents' FL-2s and ensured the medications were on the MARs. -Staff on duty transported residents to their appointments and attended the appointments with the residents. -She did not know Resident #1 had an order for triamcinolone on his current FL-2 which was never administered. -She did not check to ensure the orders were correctly transcribed to the MARs. -Staff were expected to ensure medications ordered by the PCP were received from the pharmacy, placed on residents' MARs and contact the PCP, pharmacy and her if there were any questions. -She was responsible for ensuring medications were administered as ordered by the PCP.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 612	Continued From page 15	C 612		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to use of personal protective	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 612	Continued From page 16	C 612		

equipment (PPE) by staff to reduce the risk of transmission and infection and screening of residents, staff and visitors.

The findings are:

1. Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/20/21 revealed all residents and staff should screen daily for symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty of breathing, fatigue, headache, body aches, loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting and diarrhea.

Review of the NC Department of Health and Human Services COVID-19 Long Term Care (LTC) Infection Control Assessment and Response Tool for LHD dated 10/2020 revealed staff and residents should be screened daily for fever, signs and symptoms of COVID-19.

Review of the facility's policies revealed there was no COVID-19 policy for review.

Review of the facility's visitors log revealed there were no temperatures documented on the log for any visitor from 09/10/20 to 04/21/21.

Observation of the facility on 04/20/21 at 8:48am revealed there was an infrared thermometer available for use on the medication cart.

Observation of the facility on 04/21/21 at 10:15am revealed the Administrator entered the facility without documenting her temperature.

Review of the facility's screening logs revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 612	Continued From page 17 there were no staff, visitor or resident screening logs for COVID-19 screening for review. Interview with a resident on 04/21/21 at 9:09am revealed: -His temperature was checked occasionally at the facility but not daily. -No staff asked him questions about COVID-19 symptoms. Interview with another resident on 04/21/21 at 11:20am revealed: -Staff checked his temperature at the facility sometimes, but it was not taken every day. -Staff asked him how he was doing daily, but they did not ask him about COVID-19 symptoms. Interview with a third resident on 04/20/21 at 9:57am revealed he had not had his temperature taken daily and he only had his temperature taken at his physician's appointment. Interview with the Supervisor in Charge (SIC) on 04/21/21 at 11:53am revealed: -He worked three weeks in a row and had one week off when another staff person worked. -When visitors came to the door, they had to wear a face mask and he took their temperatures. -Three residents and staff had the COVID-19 vaccine. -The residents had not tested positive for COVID-19 to his knowledge. -Two of the residents were admitted two weeks ago and had not received their COVID-19 vaccine. -He did not check his temperature or the residents' temperatures daily. -He took the residents temperatures on Saturdays because that was a "laid back" day for	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 612	Continued From page 18 the facility. -He took his temperature on Saturdays and any day he did not feel well. -He did not document his temperature. -He did not document visitor's temperatures. -He had not received any training on COVID-19. -He did not know the CDC guidelines concerning screening of visitors, staff and residents in long term care facilities. Interview with the Administrator on 04/21/21 at 12:45pm revealed: -The local health department nurse was supposed to come to the facility to provide training to staff on COVID-19. -There was no training provided to staff on COVID-19 and staff saw information about COVID-19 on the television. -She did not have a COVID-19 policy because it was not required. -She had an Infection Control policy. -Staff took the residents' temperatures when the residents did not feel well. -She did not expect staff to document the residents' temperatures unless the resident had a fever. -Staff took their temperature only if they did not feel well and she did not expect them to document the temperatures. -She did not have a screening log for visitors or staff to document if they had any symptoms of COVID-19. -She did not have a visitors screening log because she was not expecting any visitors at the facility and she was not allowing visitation at the facility. -Staff and the residents had received the COVID-19 vaccine. -She knew two of the residents had not received the COVID-19 vaccine.	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 612	Continued From page 19 -She knew the CDC guidelines regarding wearing a face mask within the facility, but she did not know the CDC guidelines concerning screening of residents, staff or visitors. -She had received emails from NC DHHS and the local health department concerning COVID-19. -She was responsible for ensuring all staff were following the guidelines of the CDC and LHD for infection control by providing daily temperature screenings for residents and staff in the facility. 2. Review of the Centers for Disease Control and Prevention (CDC) Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated 03/20/21 revealed: -Personnel should always wear a face mask at all times while they are in the facility. -COVID-19 was transmitted through droplet, therefore the mouth and nose are to be completely covered when wearing a face mask to prevent contamination and transmission of COVID-19. Review of the NC Department of Health and Human Services Guidance for Smaller Residential Settings and long-term care (LTC) facilities dated 10/2020 revealed all workers in LTC facilities, including family care homes, must wear face coverings while in the facility and those face coverings must be surgical masks as long as surgical mask supplies are available. Observation of the Administrator on 04/21/21 at 10:15am revealed she came into the facility wearing a face mask. Observation of the Supervisor in Charge (SIC) on 04/20/21 from 8:49am to 10:15am revealed he did not have a face mask on while in the facility and while getting in the facility's mini-van with the	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 612	Continued From page 20 residents. Observation of the facility 04/21/21 at 11:00am revealed there was one case of surgical face masks. -There were two cases containing smaller boxes with 50 face masks per box. -There were two cases of disposable gowns. Interview with the SIC on 04/21/21 at 11:36am revealed: -He did not wear a face mask when he was inside of the facility, but he wore a face mask when he was outside of the facility. -He had received the COVID-19 vaccine. -The local health department (LHD) nurse made a visit to the facility to administer the COVID-19 vaccinations but did not provide any teaching concerning COVID-19 in January and February 2021. -He did not wear a face mask within the facility because, he had a history of chronic asthma and actually it was chronic obstructive pulmonary disease. -When he wore a face mask, he felt like his chest was heavy. -He had not discussed this issue with his physician, nor did he have documentation from his physician concerning wearing a face mask. -He did not know the CDC or NC DHHS recommendations regarding wearing a face mask in long term care facilities. Interview with a resident on 04/21/21 at 11:15am revealed staff wore face masks when they left the facility, but staff did not wear a face mask in the facility. Interview with the Administrator on 04/21/21 at 12:45pm revealed:	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(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 612	Continued From page 21 -She did not have a COVID-19 policy for the facility. -She received emails from NC DHHS, but she had not read all of the emails. -She discussed wearing a face mask when outside of the facility with staff. -She knew the SIC had a history of asthma but did not discuss any concerns about wearing a face mask with him. -She expected staff to wear a face mask when they were in the facility and caring for the residents. _____ The facility failed to adhere to the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) guidelines during a global pandemic for the daily screening of residents and staff for fever and signs and symptoms of COVID-19 and wearing of face masks by staff at all times while in the facility to prevent the transmission and infection of the COVID-19 virus. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ A plan of protection was provided by the facility in accordance with G.S. 131D-17 on April 21, 2021 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 5, 2021.	C 612		
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	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL091018	A. BUILDING: _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF BLESSINGS FAMILY CARE HOME	1421 ROSS MILL ROAD HENDERSON, NC 27537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	Continued From page 22 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to assure each resident received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to infection prevention and control program. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to use of personal protective equipment (PPE) by staff to reduce the risk of transmission and infection and screening of residents, staff and visitors. [Refer to Tag C 0612 10A NCAC 13G .1701 (c) Infection Prevention and Control Program (Type B Violation)]	C 912		