

Received via email on 08/04/22

Division of Health Service Regulation

|                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL034092</b>                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                              | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>06/28/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WAMU'S FAMILY CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1251 SHELTER COVE</b><br><b>WINSTON-SALEM, NC 27106</b> |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |
| (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<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 06/28/22.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | C 000                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |
| C 330                                                              | 10A NCAC 13G .1004(a) Medication Administration<br><br>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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>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 medication used to for symptoms of gingivitis (a form of gum disease).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 12/21/21 revealed:<br>-Diagnoses included hypertension, seizure disorder, hypothyroidism, cognitive impairment, and mitral valve insufficiency.<br>-There was an order for peridex 0.12% solution swish and spit twice daily (used to treat gingivitis).<br><br>Review of Resident #1's April 2022 medication administration record (MAR) revealed: -There was an entry for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes | C 330                                                                                               | Administrator and staff have discussed the importance of administering Peridex mouth wash as prescribed by the patient's dentists.<br><br>All staff members must be sure to administer peridex mouth wash 2 times a day at 8 am and, at 8Pm.<br><br>Administrator will review charts quarterly to ensure that medication administration reflects prescribing professional's orders. |                                                                 |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE **esther muriuki** TITLE **administrator**

(X6) DATE **7/12/22**

*Esther Muriuki*

Reviewed and Acknowledged

*Keisha Banks*

08/12/22

Division of Health Service Regulation

STATE FORM

6899

USVZ11

If continuation sheet 1 of 8

|                                                                    |                                                                                                                              |                                                                                               |                                                                        |                                                                                                                          |                                                          |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL034092</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br>R<br><b>06/28/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WAMU'S FAMILY CARE HOME</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1251 SHELTER COVE<br/>WINSTON-SALEM, NC 27106</b> |                                                                        |                                                                                                                          |                                                          |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                 |

Division of Health Service Regulation

|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |  |  |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--|--|
| <p>C 330</p> | <p>Continued From page 1 and expectorate twice daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation peridex was administered daily from 04/01/22 through 04/30/22 at 8:00am, 12:00pm, 4:00pm, and 8:00pm.</p> <p>Review of Resident #1's May 2022 MAR revealed:<br/>-There was an entry for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. - There was documentation peridex was administered daily from 05/01/22 through 05/31/22 at 8:00am, 12:00pm, 4:00pm, and 8:00pm.</p> <p>Review of Resident #1's June 2022 MAR revealed:<br/>-There was an entry for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. - There was documentation peridex was administered daily from 05/01/22 through 05/27/22 at 8:00am, 12:00pm, 4:00pm, and 8:00pm and on 05/28/22 at 8:00am and 12:00pm.</p> <p>Observation of Resident #1's medications on hand on 06/28/22 at 1:44pm revealed:<br/>-There was an opened bottle of peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily dispensed to the facility on 07/02/21 and it was more than halfway full.<br/>-There were 6 unopened bottles of peridex 0.12% rinse dispensed to the facility on 01/04/22, 02/02/22, 03/01/22, 04/01/22, 05/02/22, and 06/02/22.</p> | <p>C 330</p> |  |  |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--|--|

|                                                                             |                                                                                                                               |                                                                                                       |                                                                                                                        |                           |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|---------------------------|
| <p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</p>                     | <p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br/><br/><b>FCL034092</b></p>                                           | <p>(X2) MULTIPLE CONSTRUCTION<br/>A. BUILDING: _____<br/><br/>B. WING _____</p>                       | <p>(X3) DATE SURVEY COMPLETED<br/><br/><b>R<br/>06/28/2022</b></p>                                                     |                           |
| <p>NAME OF PROVIDER OR SUPPLIER<br/><br/><b>WAMU'S FAMILY CARE HOME</b></p> |                                                                                                                               | <p>STREET ADDRESS, CITY, STATE, ZIP CODE<br/><b>1251 SHELTER COVE<br/>WINSTON-SALEM, NC 27106</b></p> |                                                                                                                        |                           |
| <p>(X4) ID PREFIX TAG</p>                                                   | <p>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</p> | <p>ID PREFIX TAG</p>                                                                                  | <p>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</p> | <p>(X5) COMPLETE DATE</p> |

Division of Health Service Regulation

|       |                       |       |  |  |
|-------|-----------------------|-------|--|--|
| C 330 | Continued From page 2 | C 330 |  |  |
|-------|-----------------------|-------|--|--|

Telephone interview with a pharmacy technician from the facility's contracted pharmacy revealed:

- Resident #1 had an order for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily.
- Peridex was a cycle filled medication and was automatically delivered to the facility each month with the last dispense date being on 06/02/22.
- The bottle of peridex dispensed to the facility administered twice a day should last about 23 days.

Telephone interview with a dental assistant at Resident #1's dentist's office on 06/28/22 at 1:52pm revealed:

- Peridex was used for gum health.
- The dentist last refilled Resident #1's peridex on 09/30/20 for use twice daily.
- Resident #1 was last seen in the dentist's office on 01/31/22 and had light bleeding of his gums.
- There was no documentation from the 01/31/22 visit notes regarding use of peridex.
- There was not documentation the facility contacted the dental office regarding Resident #1 not using peridex.

Interview with a medication aide (MA) on 06/28/22 at 2:22pm revealed:

- He told Resident #1 when it was time to administer the peridex rinse, but Resident #1 refused it and he could not make Resident #1 rinse.
- He thought peridex was supposed to be administered 4 times a day and he offered peridex 4 times daily.
- He assumed the order for peridex was 4 times daily because there were 4 administration times on the MAR.

|                                                                    |                                                                                                                        |                                                                                                     |                                                                                                                 |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL034092</b>                                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                               | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>06/28/2022</b>                                                 |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WAMU'S FAMILY CARE HOME</b> |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1251 SHELTER COVE</b><br><b>WINSTON-SALEM, NC 27106</b> |                                                                                                                 |
| (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                                                                                              |

Division of Health Service Regulation

|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |       |                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|-------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| C 330 | <p>Continued From page 3</p> <p>-He had not noticed the order on the MAR for peridex 10 mls twice daily.</p> <p>Interview with the Administrator on 06/28/22 at 10:35am revealed:</p> <p>-Resident #1 refused the mouth rinse a lot. -His family took him to the dentist and took care of his dental issues.</p> <p>-She thought the MAs just checked off on the MAR that the medication was administered.</p> <p>Second interview with the Administrator on 06/28/22 at 1:47pm revealed:</p> <p>-Resident #1 refused to let staff put anything in his mouth.</p> <p>-She told Resident #4's PCP ongoing that Resident #1 refused the peridex, but she had not reached out to his dentist.</p> <p>-Resident #4's PCP advised her to continue to offer peridex to Resident #1.</p> <p>Based on observation, interview, and record review, it was determined Resident #1 was not interviewable.</p> | C 330 |                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| C 342 | <p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <p>(1) resident's name;</p> <p>(2) name of the medication or treatment order;(3) strength and dosage or quantity of medication administered;</p> <p>(4) instructions for administering the medication or treatment;</p> <p>(5) reason or justification for the administration of</p>                                                                                                                                                                                                                                                                                                                                                                                            | C 342 | <p>Administrator will review the new MARs every month to ensure that they reflect the prescribing professional's instructions including :</p> <p>1, The Resident's name</p> <p>2.medication name</p> <p>3.Medication dosage</p> <p>4. indication for medication</p> <p>5.Time of administration</p> <p>6. The route of medication administration</p> <p>And any other instructions from the provider.</p> |  |

|                                                                    |                                                                                                                        |                                                                                               |                                                                                                                 |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL034092</b>                                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                         | (X3) DATE SURVEY COMPLETED<br><br><b>R<br/>06/28/2022</b>                                                       |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WAMU'S FAMILY CARE HOME</b> |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1251 SHELTER COVE<br/>WINSTON-SALEM, NC 27106</b> |                                                                                                                 |
| (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                                                                                              |

Division of Health Service Regulation

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>C 342 Continued From page 4 medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br/>(6) date and time of administration;<br/>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and<br/>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</p> <p>This Rule is not met as evidenced by:<br/>Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of medication administration records for 1 of 3 sampled residents (#1), including a medication used to for symptoms of gingivitis (a form of gum disease).</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 12/21/21 revealed:<br/>-Diagnoses included hypertension, seizure disorder, hypothyroidism, cognitive impairment, and mitral valve insufficiency.<br/>-There was an order for peridex 0.12% solution swish and spit twice daily (used to treat gingivitis).</p> <p>Review of Resident #1's April 2022 medication administration record (MAR) revealed: -There was an entry for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily, scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation peridex was administered daily from 04/01/22 through 04/30/22 at 8:00am, 12:00pm, 4:00pm, and</p> | <p>C 342</p> <p>Administrator has corrected the current MAR to reflect the dentist's order for peridex mouth wash, swish and spit two times a day at 8 am and 8 pm.<br/>Perdiex will be administered and charted in the MAR 2 times a day at 8 am and 8 pm.</p> <p>Staff members will chart when the patient refuses to use peridex with an "R" indicating "Refused" whenever the resident refuses the medication.</p> <p>The order for peridex twice a day has been faxed tp the pharmacy requesting the pharmacy to correct future MARs from 4 times a day to 2 times a day</p> <p>Administrator will notify the prescribing health professional if the resident refuses to take medication.</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                    |                                                                                                                        |                                                                                                     |                                                                                                                                           |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL034092</b>                                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                               | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>06/28/2022</b>                                                                           |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WAMU'S FAMILY CARE HOME</b> |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1251 SHELTER COVE</b><br><b>WINSTON-SALEM, NC 27106</b> |                                                                                                                                           |
| (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)<br><br>(X5) COMPLETE DATE |

Division of Health Service Regulation

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| <p>C 342 Continued From page 5</p> <p>8:00pm.</p> <p>Review of Resident #1's May 2022 MAR revealed:<br/>-There was an entry for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily, scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation peridex was administered daily from 05/01/22 through 05/31/22 at 8:00am, 12:00pm, 4:00pm, and 8:00pm.</p> <p>Review of Resident #1's June 2022 MAR revealed:<br/>-There was an entry for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily, scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation peridex was administered daily from 05/01/22 through 05/27/22 at 8:00am, 12:00pm, 4:00pm, and 8:00pm and on 05/28/22 at 8:00am and 12:00pm.</p> <p>Observation of Resident #1's medications on hand on 06/28/22 at 1:44pm revealed:<br/>-There was an opened bottle of peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2 minutes and expectorate twice daily dispensed to the facility on 07/02/21 and it was more than halfway full.<br/>-There were 6 unopened bottles of peridex 0.12% rinse dispensed to the facility on 01/04/22, 02/02/22, 03/01/22, 04/01/22, 05/02/22, and 06/02/22.</p> <p>Telephone interview with a pharmacy technician from the facility's contracted pharmacy revealed: - Resident #1 had an order for peridex 0.12% rinse swish 10 mls in mouth or throat for 1-2</p> | <p>C 342</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|

|                                                                    |                                                                                                                        |                                                                                               |                                                                                                                                           |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL034092</b>                                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                         | (X3) DATE SURVEY COMPLETED<br><br><b>R<br/>06/28/2022</b>                                                                                 |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WAMU'S FAMILY CARE HOME</b> |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1251 SHELTER COVE<br/>WINSTON-SALEM, NC 27106</b> |                                                                                                                                           |
| (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)<br><br>(X5) COMPLETE DATE |

Division of Health Service Regulation

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|
| <p>C 342 Continued From page 6 minutes and expectorate twice daily.</p> <p>-Peridex was a cycle filled medication and was automatically delivered to the facility each month with the last dispense date being on 06/02/22. -It was possible peridex was originally ordered for 4 times daily and it was not changed by the pharmacy to twice daily.</p> <p>-The facility had not called to change the entry on the MAR to only two spaces for entering documentation of administration.</p> <p>Interview with a medication aide (MA) on 06/28/22 at 2:22pm revealed:</p> <p>-He told Resident #1 when it was time to administer the peridex rinse, but Resident #1 refused it and he could not make Resident #1 rinse.</p> <p>-Resident #1 refused peridex most of the time, but he was not sure about how to document when Resident #1 refused a medication.</p> <p>-He usually just documented his initials on the MAR when Resident #1 refused just as he would as if medication was administered. -He thought peridex was supposed to be administered 4 times a day and he offered peridex 4 times daily and documented his initials 4 times daily.</p> <p>-He assumed the order for peridex was 4 times daily because there were 4 administration times on the MAR.</p> <p>-He had not noticed the order on the MAR for peridex 10 mls twice daily.</p> <p>Interview with the Administrator on 06/28/22 at 2:07pm revealed:</p> <p>-She expected MAs to document on the MAR as medications were given to residents.</p> <p>-She did not notice prior to today that peridex was scheduled to be administered 4 times daily on the MAR and that MAs documented administration 4</p> | <p>C 342</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|

|                                                                    |                                                                                                                        |                                                                                                     |                                                                                                                                           |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL034092</b>                                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                               | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>06/28/2022</b>                                                                           |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WAMU'S FAMILY CARE HOME</b> |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1251 SHELTER COVE</b><br><b>WINSTON-SALEM, NC 27106</b> |                                                                                                                                           |
| (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)<br><br>(X5) COMPLETE DATE |

Division of Health Service Regulation

|       |                                                                                                                                                                                                                                                                                                                                                                                                      |       |  |  |
|-------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|
| C 342 | <p>Continued From page 7 times daily in April, May, and June 2022. -She documented administration of peridex 4 times daily on multiple days in June 2022.</p> <p>-She made a mistake in documenting and it must have been an oversight when the MAs documented administration 4 times daily. -She was responsible for reviewing the MARs once a month, but she had not reviewed them this month.</p> | C 342 |  |  |
|-------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|--|--|