

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____

TITLE

(X6) DATE

STATE FORM 7-60

6899

SLE411

09/01/2022

If continuation sheet 1 of 5

Reviewed and Acknowledge
u 09/02/2022

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL024014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 07/07/2022
NAME OF PROVIDER OR SUPPLIER SMITH FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 492 SPEARMAN ROAD BOLTON, NC 28423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 1 his short-term memory. -Resident #1 required a calendar to document reminders and daily routines to aide in memory and functionality. a. Observation of Resident #1 on 07/07/22 at 8:20am revealed: -The resident was sitting on the couch in the living room. -The resident required repeated statements in loud speech when spoken to prior to him responding. Review of Resident #1's Primary Care Provider (PCP) visit note dated 05/31/22 revealed: -The resident and facility staff reported decrease hearing in both the resident's ears. -Examination revealed diminished hearing in both ears. -The resident was referred to audiology for decreased hearing in both ears. Review of Resident #1's PCP referral dated 06/06/22 revealed: -Diagnoses included bilateral hearing loss. -The resident was referred to an audiologist. -The audiologist office contact information was documented. -There was documentation to contact the facility. Interview with the Administrator on 07/07/22 at 5:00pm revealed: -She knew Resident #1's PCP referred the resident to an audiologist, but she had not had time to follow up regarding the status of the appointment. -She planned to contact the audiologist this morning (07/07/22) regarding the status of Resident #1's referral appointment. -She was responsible for all referrals and	C 246	10A NCAC 13G .0902(b) Health Care The Administrator conducted a chart audit to assure referral and follow-up meet residents' routine and acute health care needs.	07/18/2022

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C 246	Continued From page 2 scheduling resident appointments. Attempted telephone interview with Resident #1's PCP on 07/07/22 at 2:00pm was unsuccessful. Attempted telephone interview with the audiologist documented on the referral on 07/07/22 at 2:10pm was unsuccessful. Attempted telephone interview with Resident #1's family member on 07/07/22 at 2:30pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. b. Review of Resident #1's urology operative report dated 10/07/21 revealed: -Pre-operative diagnoses included a bulbar urethral stricture. -Post-operative diagnoses included a narrowed penile urethra and bulbar stricture. -A cystoscopy with urethral dilation and difficult urinary catheter placement was performed. -The findings were a narrowed penile urethra, a bulbar urethral stricture (obstruction of urine flow through the urethra which impedes the body's ability to pass urine), an enlarged prostate, and a trabeculated bladder (thickened bladder walls due to repeated or chronic obstructions in the urethra). -The resident was discharged with a urinary catheter. -A post-operative appointment was scheduled for 10/11/21. Telephone interview with the nurse for Resident #1's urologist office on 07/07/22 at 2:30pm revealed:	C 246			

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C 246	Continued From page 3 -Resident #1 was last treated by the urologist on 10/11/22 as a follow up from surgery on 10/07/22. -On 10/11/22, the resident's urinary catheter was removed, and a return appointment made for 10/26/21. -The resident did not show for the 10/26/21 appointment. -Had the resident kept the 10/26/21 appointment, a bladder scan would have been performed to determine if the resident had urinary retention. -Urinary retention could cause urinary tract infections requiring antibiotics or could cause pain. Review of Resident #1's facility record revealed: -There was no documentation of a post-operative 10/11/21 urology visit. -There was no documentation that indicated the resident had a second post-operative urology appointment scheduled for 10/26/21. Review of Resident #1's PCP visit note dated 11/23/21 revealed: -Diagnosis included BPH with lower urinary tract symptoms. -The resident was under the care of a urologist. -The resident reported urinary frequency of every 15 to 20 minutes which limited the amount of water the resident was comfortable drinking. -The resident was prescribed Oxybutynin ER 5mg daily (used to treat overactive bladder). Review of Resident #1's PCP visit note dated 05/31/22 revealed: -The resident was treated for BPH. -Diagnoses included BPH with lower urinary tract symptoms. -The lower urinary tract symptoms were not documented. -The resident was currently being administered	C 246			

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C 246	Continued From page 4 Finasteride (used to treat BPH). Interview with the Administrator on 07/07/22 at 3:00pm revealed: -Resident #1 was not incontinent of urine. -It was the responsibility of the facility to transport residents to medical appointments. -She electronically documented all resident medical appointments on an electronic calendar. -She printed the electronic calendar the first of every month and posted on the wall behind her desk to reference. -She updated the electronic calendar through out the month and printed a new calendar when needed. -She did not have the electronic calendar for October 2021 because she deleted the calendars the end of every year. -She did not keep the printed copy of the electronic calendars. -She always documented follow up appointments on a page in the resident's record when she transported residents to their appointments. -She did not know Resident #1 had a post-operative urology appointment scheduled for 10/26/21 because she did not transport the resident to his 10/11/21 urology appointment. Attempted telephone interview with Resident #1's family member on 07/07/22 at 2:30pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	C 246			