Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013046	A. BUILDING: _____ B. WING _____	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANNAPOLIS FAMILY CARE HOME	2216 KANNAPOLIS HIGHWAY CONCORD, NC 28027

(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 and the Cabarrus County Department of Social Services conducted an annual survey on April 25.2025.	C 000	(1.) Facility Nurse/ supervisor will audit each resident record monthly + report to administrator in spreadsheet of updated FL2's. Facility Nurse/ Supervisor will complete/ensure FL-2's are not out of date + will get completed if they are due. (2.) Facility Nurse will monitor + if there is a problem report to administrator	5-27-25
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the home and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (#2 and #3) FL2's were updated annually. The findings are: 1.Review of Resident #2's current FL2 dated 01/04/24 revealed diagnoses included senile degeneration of brain (dementia), atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) failure to thrive and unrepaired femur fracture.	C 203		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: administrator — (X6) DATE: 5/27/25

Reviewed and acknowledged by MH on 05/30/2025

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C 203	Continued From page 1 Review of Resident #2's Resident Register revealed an admission date of 01/05/24. Review of Resident #2's record on 04/25/25 revealed there was not an updated FL2 completed since 01/04/24. Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on 04/25/25 at 12:20pm. 2.Review of Resident #3's current FL-2 dated 02/27/24 revealed diagnosis included senile degeneration(dementia), gastro esophageal reflex (acid reflux), hyperlipidemia, dementia with agitation and heart failure. Review of Resident #3's Resident Register revealed an admission date of 03-01-24. Review of Resident #3's record on 04/25/25 revealed there was not an updated FL2 completed since 02/27/24. Refer to the interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to the interview with the Administrator on 04/25/25 at 12:20pm. _____ Interview with the Facility Nurse on 04/25/25 at 10:05am revealed: -She was responsible for ensuring the FL2 was up to date. -She thought she had a copy in her office which was a thirty-minute drive from the facility.	C 203	(3.) Monitoring will take place every 30 days +- reported on the 1st of the month	5-27-25

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C 203	Continued From page 2 -She was aware the residents' FL2 were to be done upon admission and annually thereafter. -She was responsible for completing the FL2 and to make sure it was signed by the Primary Care Provider (PCP). -She thought she gave it to the hospice nurse who would give it to the hospice PCP for his signature. -Usually, the hospice Nurse would bring it right back. -She did audit resident records every six to eight weeks. -She kept a calendar for tracking things like the residents FL2. -She was not sure how she missed the residents' FL2's being out of date. Interview with the Administrator on 04/25/25 at 12:20pm revealed: -She was not aware that Resident #3's FL2 was not up to date. -The Facility Nurse was responsible for ensuring Residents FL2 was completed annually.	C 203		
C 206	10A NCAC 13G .0702 (e) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following:	C 206	1.1 Facility Nurse 5.27.25 has reached out to providers + obtained signatures + moving forward will contact PCP 30 days prior to expiration	

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C 206	Continued From page 3 (1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care; (2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset; (3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status including orders for therapeutic diets; (4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints; (5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication; (6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and (7) additional information as determined by the physician or physician extender to be necessary for the care of the resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the	C 206	1.2. Facility nurse will audit charts monthly & report to administrator in spreadsheet of completed documentation. Facility RN will contact provider to obtain signatures 30 days prior to duedate. 1.3 Facility Nurse will monitor & report to administrator if problem	5.27.25 5.27.25

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C 206	Continued From page 4 facility failed to ensure 1 of 3 sampled residents (#1) FL-2 was signed by the Primary Care Provider (PCP). The findings are: Review of Resident #1's current FL2 dated 01/29/25 revealed: -Diagnosis included included hyperkalemia, essential hypertension, heme positive stool (blood within the stool), obstructive uropathy, acute renal failure, urinary retention, atrial fibrillation, anemia, stage 3 chronic kidney disease, vascular dementia, acute kidney injury and isolation. -There was no documentation of a Primary Care Provider (PCP) signature. Interview with the Facility Nurse on 04/25/25 at 10:05am revealed: -She was responsible for ensuring the FL2 was complete including signatures by the PCP - She always accepted FL2's from the hospital and it was never a problem. -She did audit resident records every six weeks to eight weeks. -She was not sure how she missed the FL2 was not signed by the PCP. Interview with the Administrator on 04/25/25 at 12:20pm revealed: -She was not aware that Resident #1's FL2 was not signed by the PCP. -The Facility Nurse was responsible for ensuring Resident #1's FL2 had a signature by the PCP.	C 206	1.4 Monitoring will take place every 30 days on the 1st of the month.	5.27.25
C 218	10A NCAC 13G .0704 (b) Resident Contract, Information on Facility 10A NCAC 13G .0704 Resident Contract,	C 218		

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C 218	Continued From page 5 Information On Facility, and Resident Register (b) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D- 4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf, at no charge. The facility may use a resident information form other than the Resident Register	C 218	1.1. All registries were signed by facility RN + are to be signed by whoever is admitting the patient which is primarily the facility RN 1.2. Facility RN is required moving forward to send proof of signature at admission to the administrator.	5.27.25 5.27.25

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C 218	Continued From page 6 as long as it contains same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, and #3) Resident Register was signed by the Administrator within 72 hours of admission to the facility. The findings are: 1.Review of Resident #1's current FL2 dated 02/11/2025 revealed diagnosis included hyperkalemia, essential hypertension, heme positive stool (blood within the stool), obstructive uropathy, acute renal failure, urinary retention, atrial fibrillation, anemia, stage 3 chronic kidney disease, vascular dementia, acute kidney injury and isolation. Review of Resident #1's Resident Register revealed: -Resident #1 was admitted to the facility on 02/11/25. -The Resident Register was signed by Resident #1's responsible person on 02/11/25. -There was no Administrator or designee signature. Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on	C 218	The registries shall be ✓ every 30 days & other documentation 5.27.25 1.3-Facility RN will monitor & report to administrator if there is an issue 5.27.25 1.4 Monitory will take place every 30 days.	

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C 218	Continued From page 7 04/25/25 at 12:20pm. 2. Review of Resident #2's current FL2 dated 01/04/24 revealed diagnoses included senile degeneration of brain (dementia), atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) failure to thrive and unrepaired femur fracture. Review of Resident #2's Resident Register revealed: -There was an admission date of 01/05/24. -There was no Resident or Resident's Responsible Person signature. -There was no Administrator or designee signature. Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on 04/25/25 at 12:20pm. 3. Review of Resident #3's current FL-2 dated 02/27/2024 revealed diagnosis included senile degeneration, gastro esophageal reflex, hyperlipidemia, dementia with agitation and heart failure. Review of Resident #3's Resident Register revealed: -The Resident Register was signed by Resident #3's responsible person 02-29-2024. -There was no documentation the Administrator signed the Resident Register within 72 hours of admission. Refer to interview with the Facility Nurse on 04/25/25 at 10:05am .	C 218		

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C 218	Continued From page 8 Refer to interview with the Administrator on 04/25/25 at 12:20pm. Interview with the Facility Nurse on 04/25/25 at 10:05am revealed: -The Resident Register is part of the admission packet which the Resident or Resident's responsible party would fill out and sign. -The Administrator would be responsible for signing the Resident Register. -She was not aware that she could sign the Resident Register. Interview with the Administrator on 04/25/25 at 12:20pm revealed: -The Facility Nurse is with the families upon admission. -The Facility Nurse would be responsible for signing the Resident Register as the representative of the facility.	C 218		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and	C 231	1.1 Facility RN will contact providers immediately & obtain signed Care plan. 1.2. Moving forward	5.27.25

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C 231	Continued From page 9 physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents had an assessment and care plan updated annually (#3). The findings are: Review of Resident #3's current FL-2 dated 02/27/24 revealed diagnosis included senile degeneration (dementia), gastro esophageal reflex (acid reflux), hyperlipidemia, dementia with agitation and heart failure. Review of Resident #3's record revealed: -She was on Hospice care as of 05-09-24. -A care plan dated 03/04/24 was signed by the Facility Nurse but not signed by the Primary Care Provider (PCP). -There was no annual care plan completed after 03/04/24. Interview with the Facility Nurse on 04/25/25 at 10:05am revealed: -She was responsible for ensuring the care plan was completed annually or if there was a significant change in a Residents health. -She was responsible for completing the	C 231	facity RN is to provide the 5/27/25 administrator with documentation that all careplans have been completed. This process will be monitored q 30 days. after admission, Facility RN will provide signed care plan proof w/in 2 weeks of admission	

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C 231	Continued From page 10 assessment for Resident #3 and and to make sure it was signed by the PCP. -She thought she gave it to the hospice nurse who would give it to the hospice PCP for his signature. -Usually, the hospice Nurse would bring it right back. -She did audit resident records every six to eight weeks. -She kept a calendar for tracking things like the care plan. -She was not sure how she missed updating the Resident #3's care plan. Interview with the Administrator on 04/25/25 at 12:20pm revealed: -She was not aware that Resident #3's care plan was not up to date. -The Facility Nurse was responsible for ensuring Residents care plan was completed annually and signed by the PCP.	C 231	1.3 Facility RN will monitor 1.4 Monitory will take place q 30 days + 2 weeks post admission.	5.27.25
C 240	10A NCAC 13G .0802(e) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews and interviews, the	C 240	1.1. Facility RN has obtained signatures from providers. 1.2 Facility RN will audit records q 30 days	5.27.25

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C 240	Continued From page 11 facility failed to ensure 2 of 3 sampled residents (#1 and #2) Primary Care Provider (PCP) signed and dated their Resident Care Plan within 15 days of completion of the assessments. The findings are: 1.Review of Resident #1's current FL2 dated 02/12/25 revealed diagnosis included hyperkalemia, essential hypertension, heme positive stool (blood within the stool), obstructive uropathy, acute renal failure, urinary retention, atrial fibrillation, anemia, stage 3 chronic kidney disease, vascular dementia, acute kidney injury and isolation. Review of Resident #1's record revealed: -The care plan was signed and dated by the facility's Registered Nurse (RN) on 02/12/25. -The care plan had not been signed and dated by the resident's Primary Care Provider (PCP). Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on 04/25/25 at 12:20pm. 2.Review of Resident #2's current FL2 dated 01/04/24 revealed diagnoses included senile degeneration of brain (dementia), atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) failure to thrive and unrepaired femur fracture. Review of Resident #2's Care Plan revealed the assessment was completed and signed by the RN on 01/03/25. Review of Resident #2's Care Plan dated 01/03/25 revealed it had not been signed and	C 240	and will also be responsible for checking records 15 days past admission & report to administrator if an issue. Facility RN also will reach out to provider at admission for signature. 5.27.25 1.3. Facility RN 5.27.25 will monitor. 1.4 Monitoring will occur every 30 days + 15 days after admission of a resident.	

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C 240	Continued From page 12 dated by the resident's Primary Care Provider (PCP). Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on 04/25/25 at 12:20pm. Interview with the Facility Nurse on 04/25/25 at 10:05am revealed: -She was responsible for ensuring the care plan was completed annually or if there was a significant change in a residents health. -She was responsible for completing the assessments and to make sure it was signed by the PCP. -She thought she gave care plan to the hospice nurse who would give it to the hospice PCP for his signature. -Usually, the hospice Nurse would bring it right back. -She did record reviews every six to eight weeks. -She kept a calendar for tracking things like the care plan. -She was not sure how she missed updating the care plan. Interview with the Administrator on 04/25/25 at 12:20pm revealed: -She was not aware that Resident's care plans were not up to date. -The Facility Nurse was responsible for ensuring Residents care plan were completed annually and signed by the PCP.	C 240		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support	C 254		

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C 254	Continued From page 13 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1,#2 and #3) Licensed Health Professional Support (LHPS) evaluations were completed quarterly. The findings are: 1. Review of Resident #1's current FL-2 dated 02/11/2025 revealed diagnosis included hyperkalemia, essential hypertension, heme positive stool (blood within the stool), obstructive	C 254	1.1 Facility RN has completed these & will ensure completion moving forward. 1.2. Facility RN will monitor every 30 days + 15 days after admission. Facility RN will audit monthly & complete any due LHPS assessments.	5.27.25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013046	A. BUILDING: _____ B. WING _____	04/25/2025

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C 254	Continued From page 14 uropathy, acute renal failure, urinary retention, atrial fibrillation, anemia, stage 3 chronic kidney disease, vascular dementia, acute kidney injury and isolation. Review of Resident's #1 Resident Register revealed he was admitted to the facility on 02/11/25. Review of Resident #1's current care plan dated 02/12/25 revealed: -Resident #1 had medically related personal care needs and was totally dependent with toileting, ambulation, bathing, dressing, grooming and transferring. -The care plan dated 02/12/25 include licensed health professional support (LHPS) personal care task for indwelling foley catheter (catheter care). Review of Residents record and there was no documentation of a current LHPS. Observation on 04/25/25 revealed: -Resident #1 was observed receiving a bed bath by his home health provider. -Resident #1 was observed with an indwelling foley catheter. Interview with a Medication Aide on 04/25/25 at 8:45am revealed: -Resident #1 was admitted with a foley catheter. -The foley catheter is changed by home health and staff empty and clean the urine bag. Interview with the Facility Nurse on 04/25/2025 at 1:00pm revealed she knew she had completed Resident #1's LHPS, but thought it may be in her office which was a thirty minute drive from the facility.	C 254	1.3 Facility RN 5.27.25 will be responsible 1.4 Monitory will take Place monthly + 15 days after admission.	

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C 254	Continued From page 15 Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on 04/25/25 at 12:20pm. 2. Review of Resident #2's current FL2 dated 01/04/24 revealed: -Diagnoses included senile degeneration of brain (dementia), atrial fibrillation (irregular heartbeat), hypertension (high blood pressure) failure to thrive and unrepaired femur fracture. -The recommended level of care was Family Care Home. -The resident was non-ambulatory. -The resident was incontinent of bowel and bladder. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation revealed: -The current LHPS evaluation was completed and signed by the Facilty Nurse on 10/03/24 and included personal care tasks documented as feeding techniques for residents with swallowing problems, care for pressure ulcers up to and including a Stage II pressure ulcer, medication administration through enemas, suppositories or vaginal douches, and transferring semi-ambulatory or non-ambulatory residents. -The previous LHPS evaluation was dated 07/03/24 and included personal care tasks documented as transferring semi-ambulatory or non-ambulatory residents and medication administration through enemas, suppositories or vaginal douches. Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on	C 254		

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C 254	Continued From page 16 04/25/25 at 12:20pm. 3.Review of Resident #3's current FL-2 dated 02/27/24 revealed diagnosis included senile degeneration, gastro esophageal reflex, hyperlipidemia, dementia with agitation and heart failure. Review of Resident #3's record revealed: -The most recent Licensed Health Professional Support (LHPS) evaluation was completed on 09-04-24. -The LHPS evaluation was signed by the Facility Nurse on 09-04-24. -The most recent LHPS evaluaiton included tasks for transfers and placing a wedge device between Resident #3's legs. -There was no additional LHPS evaluation completed for Resident #3. Refer to interview with the Facility Nurse on 04/25/25 at 10:05am. Refer to interview with the Administrator on 04/25/25 at 12:20pm. _____ Interview with the Facility Nurse on 04/25/25 at 10:05am revealed: -She was responsible for ensuring the LHPS evaluations were up to date. -She was aware the LHPS should be completed quarterly. -She did audit resident records every six to eight weeks. -She kept a calendar for tracking things like the LHPS. -She was not sure how the LHPS was missed for all three residents.	C 254		

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C 254	Continued From page 17 Interview with the Administrator on 04/25/25 at 12:20pm revealed: -She was not aware that three of the Residents LHPS was not up to date. -The Facility Nurse was responsible for ensuring Residents LHPS was completed quarterly.	C 254		