| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JONES FAMILY CARE HOME | 3620 BARWELL ROAD RALEIGH, NC 27610 |

| (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 |
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| C 059 | 10A NCAC 13G .0310 (b) Storage Areas<br><br>10A NCAC 13G .0310 Storage Areas<br><br>(b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use.<br><br>This Rule is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to assure cleaning agents and other potentially hazardous substances, such as bleach, were stored separately and securely. The findings are:<br><br>Observations on 10/8/09 at 9:15 a.m. revealed a one gallon of bleach was not stored in a separate locked area. The container of bleach was on the kitchen counter. The warning label on the container revealed bleach was a moderate eye and skin irritant; and may be harmful if swallowed or inhaled.<br><br>Interview with Staff A ( Supervisor in charge) on 10/8/09 at 9:30 a.m. revealed bleach is used to pour in the dishwasher to help sanitize the dishes because there is no hot water running to the kitchen area.<br><br>Interview with the Administrator at 9:50 a.m. on 10/8/09 revealed she was not aware the cleaning supplies were stored in an unlocked area on the kitchen counter. | C 059 | | |
| C 102 | 10A NCAC 13G .0317 (a) Building Service Equipment<br><br>10A NCAC 13G .0317 Building Service | C 102 | | |

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| C 102 | Continued From page 1<br>Equipment<br><br>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION.<br><br>Based on observation and staff interview, the facility failed to maintain the building and electrical equipment, such as the facility's smoke alarms and clothes dryer, in a safe and operating condition. The findings are:<br><br>1. During the initial facility tour conducted on 10/6/9 at 8:30 a.m., two "No Smoking" signs were observed posted in the facility. One sign was posted on the male residents' bedroom door adjacent to the living room. The other sign was posted on the door in hallway leading to the other resident bedrooms. Staff A's bedrooms was also on this hallway.<br><br>Based on observation on 10/6/09 at 9:15 a.m. there was a beeping sound coming from the smoke alarms. Subsequent interview with staff from Emergency Management Services and DHSR Construction Section revealed the sound from the smoke alarms indicated the batteries needed to be changed.<br><br>Interview with a construction section staff on 10/8/09 at 9:40 a.m. revealed he smelled smoke in Staff A's bedroom when entering the room. The construction section staff reported observation of several cigarettes butts in ash | C 102 | | |

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| C 102 | Continued From page 2<br>trays in Staff A's bedroom.<br><br>Interview with the Staff A on 10/8/09 at 9:40 a.m. revealed, "I took two puffs of a cigarette and put it out". Staff A stated that she knew there was "no smoking" allowed in the facility.<br><br>Interview with the administrator on 10/8/09 at 10:10 a.m. revealed there is to be "No Smoking" in the facility and there were signs posted on the hallway door toward the bedrooms. The administrator reported that the facility has no smoking policy, because the residents know they are not supposed to smoke in the facility. The administrator was not aware Staff A had been smoking in her bedroom.<br><br>On 10/8/09 at 9:50 a.m. the construction unit staff revealed that there was no operational smoke alarms in Staff A's bedroom and the alarms were hanging from the ceilings in the bedroom and in the third bedroom where residents resided.<br><br>2. Confidential interview with a resident revealed the facility's clothes dryer has been broken for a few weeks. The resident stated wet clothes had to be hung out to dry on the deck and in the resident's bedroom. The resident revealed the facility was aware the dryer was broken.<br><br>Interview with Staff A (supervisor in charge) on 10/8/09 at 9:30 a.m. revealed the dryer was broken and did not know when if would be fixed.<br><br>Interview with the administrator on 10/8/09 at 10:15 a.m. revealed the dryer was broken. There was no explanation of when the dryer would be repaired or replaced.<br><br>THE DATE OF CORRECTION SHALL NOT | C 102 | | |

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| C 102 | Continued From page 3<br>EXCEED OCTOBER 30, 2009. | C 102 | | |
| C 132 | 10A NCAC 13G. 0403(b) Qualifications Of Medication Staff<br><br>10A NCAC 13G. 0403 Qualifications Of Medication Staff<br>(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall successfully pass the written examination within 90 days after successful completion of the clinical skills validation portion of a competency evaluation according to Rule .0503 of this Subchapter.<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATED OF CORRECTION<br><br>Based on interviews and record review, the facility failed to assure that 1 of 1 staff (Staff A) who administered medications had successfully passed the written exam within 90 days of successful completion of the clinical skills validation portion of the competency evaluation. The findings are:<br><br>Review of Staff A's clinical skills competency checklist revealed her date of hire was 3/6/09. Staff A's medication administration clinical validation was completed on 3/30/09. There was no documentation provided to show Staff A had successfully passed the written exam within 90 days of completion of the clinical skills checklist.<br><br>Review of the July, August, September 2009's (MARs) medication administration records revealed Staff A had administered medications to | C 132 | | |

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| C 132 | Continued From page 4<br>all the residents.<br><br>Interview with Staff A on 10/6/09 at 8:30 p.m. revealed Staff A had administered medications to all residents since the competency validation on "3/30/09".<br><br>Confidential resident interviews revealed Staff A administered medications to the residents since 3/30/09.<br><br>Observation on 10/8/09 at 8:40 a.m. revealed the administrator instructing Staff A to give the residents their medications so they could leave for their day program. Staff A obtained several clear, plastic pill organizers containing medications.<br><br>Observations and interview with Staff A on 10/8/09 at 8:40 a.m. revealed that she had pre-poured the medications. The medications for the residents had been placed in a four-slot pill organizer labeled with each resident's name. Staff A stated the first two slots were for the morning administration and the last two slots were for the evening administration.<br><br>Observation on 10/8/09 at 8:45 a.m. revealed Staff A asked Resident #4 to hold out his hand; Staff A then poured 6 pills in the resident's hand and walked away.<br><br>Resident #2 held out her hand and Staff A poured 9 pills in the residents hand. The resident walked away and Staff A did not observe the resident to take the medications.<br><br>Resident #6 had two pills poured in his hand.<br><br>Continued observation revealed Staff A poured 6 | C 132 | | |

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| C 132 | Continued From page 5<br>pills in the Resident #3's hand while the resident was sitting in the front seat of a vehicle.<br><br>During the same observation, none of the residents were offered anything to drink. When asked about this, Staff A stated Resident #3 and Resident #4 never drink anything with their medications. It was further revealed the other residents get what they want to drink.<br><br>Observation on 10/8/09 at 8:50 a.m. revealed the Administrator prepared three small plastic cups of water and instructed Staff A to give the water to the residents. Staff A stated the residents had already been given their medications except Resident #5. The administrator took the cups back to the kitchen. Resident #5 was given 3 pills with a small plastic cup of water by the administrator.<br><br>Interview with the Administrator on 10/8/09 at 10:30 a.m. revealed Staff A's medication administration skills had been validated on 3/30/09 and had been revalidated 8/19/09 by the registered nurse. The Administrator stated it was okay for Staff A to administer medications. The administrator confirmed Staff A was currently working as a medication aide/supervisor in charge. When the surveyor explained the rule to the administrator, the administrator revealed she would give medications until the medication aide/supervisor in charge passes the medication written examination.<br><br>Based on record review, interview and observations, discrepancies were identified with medication orders and medication administration for 6 of 6 residents. Refer to findings for Tag C330 10A NCAC 13G .1004 Medication Administration. | C 132 | | |

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| C 132 | Continued From page 6<br><br>THE DIRECTED DATE OF CORRECTION SHALL NOT EXCEED October 30, 2009. | C 132 | | |
| C 140 | 10A NCAC 13G .0405(a)(b) Test For Tuberculosis<br><br>10A NCAC 13G .0405 Test For Tuberculosis<br>(a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.<br>(b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to assure upon employment 1of 2 employees (Staff B) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the North Carolina Department of Health and Human Services Division of Public Health Epidemiology Section-TB Control. The findings are:<br><br>Record review of the Staff B's agency orientation sheet (unknown date) revealed TB screening was checked off, but no two-step tuberculin skin test (TST) was documented. | C 140 | | |

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| C 140 | Continued From page 7<br><br>Interview on 10/7/09 at 4:20 p.m. with Staff B (certified nursing assistant) revealed she was employed through a private duty agency. Staff B revealed she gave her tuberculosis (TB) screening reports to the facility on her first work day approximately 1 month ago (unknown date.)<br><br>Interview on 10/8/09 at 10:45 a.m. with the Administrator revealed she could not locate a TB skin test for Staff B. | C 140 | | |
| C 145 | 10A NCAC 13G .0406(a)(5) Other Staff Qualifications<br><br>10A NCAC 13G .0406 Other Staff Qualifications<br>(a) Each staff person of a family care home shall:<br>(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION.<br><br>Based on staff interviews and record reviews, the facility failed to assure 1 of 2 staff members (Staff B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry. The findings are:<br><br>Record review of Staff B's employee record revealed no documentation regarding the employee's status with the North Carolina Health Care Personnel Registry.<br><br>Interview on 10/7/09 at 4:20 p.m. with Staff B revealed she was employed through a private duty agency. She indicated she brought | C 145 | | |

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| C 145 | Continued From page 8<br>employee forms to the facility on her first work day approximately 1 month ago (Staff B could not recall a date). Staff B could not recall if the private duty agency sent information regarding her status with the North Carolina Health Care Personnel Registry.<br><br>Interview on 10/8/09 at 10:45 a.m. with the Administrator revealed she could not locate Staff B's status with the North Carolina Health Care Personnel Registry from the private duty agency.<br><br>THE DIRECTED DATE OF CORRECTION SHALL NOT EXCEED OCTOBER 30, 2009 | C 145 | | |
| C 147 | 10A NCAC 13G .0406(a)(7) Other Staff Qualifications<br><br>10A NCAC 13G .0406 Other Staff Qualifications<br>(a) Each staff person of a family care home shall:<br>(7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION.<br><br>Based on interviews and record reviews, the facility failed to assure 1 of 2 employees (Staff B) have a criminal background check before employment. The findings are:<br><br>Record review of Staff B's employee record revealed no documentation of a criminal background check prior to employment.<br><br>Interview on 10/7/09 at 4:20 p.m. with Staff B, revealed she was employed as a certified | C 147 | | |

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| C 147 | Continued From page 9<br>nursing assistant through a private duty agency. She indicated she brought her employee forms to the facility on her first work day approximately 1 month ago (no date available.) She could not recall if the private duty agency sent a copy of the criminal background check.<br><br>Interview on 10/8/09 at 10:45 a.m. with the Administrator revealed she could not locate Staff B's work forms.<br><br>THE DIRECTED DATE OF CORRECTION SHALL NOT EXCEED October 30, 2009. | C 147 | | |
| C 185 | 10A NCAC 13G .0601(a) Management and Other Staff<br><br>10A NCAC 13G .0601Mangement and Other Staff<br>(a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE A VIOLATION WITH A DIRECTED PLAN OF CORRECTION<br><br>Based on observation,and interview the administrator failed to assure that all required duties were carried out in the home. The findings | C 185 | | |

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| C 185 | Continued From page 10<br>are:<br><br>Interview on 10/6/09 at 8:30 p.m. with Staff A revealed she was responsible for the daily operations in the absence of the administrator. Staff A stated that the administrator was usually out of town and comes to the facility two to three times a month. Staff A was not aware of any special requirements for working as supervisor in charge.<br><br>During the survey, the following areas of non-compliance were identified:<br><br>1. Based on observations, interviews and record review, the facility failed to provide supervision for 4 of 4 residents (#2, #3, #4 and #6) who were left unsupervised, waiting for transportation back to the facility, outside of a local community building on three known occasions (7/30/09, 8/5/09 and 10/6/09) [Refer to Tag 243 10A NCAC 13G .0901(b) Personal Care and Supervision]<br><br>2. Based on observation, record review and staff and resident interviews, the facility failed to assure every resident had the right to receive care and services which were adequate, appropriate and in compliance with rules and regulations.[Refer to Tag 912 G.S. 131D-21(2) Declaration of Residents Rights]<br><br>3. Based on observation, interview and record review the facility failed to assure staff met the minimum safety requirements by assuring that smoking was prohibited inside the facility. [ Refer to to Tag 502 G.S. 131D-4.4d]<br><br>4. Based on interviews and record review, the facility failed to assure that 1 of 1 staff (Staff A) who administered medications had successfully | C 185 | | |

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| C 185 | Continued From page 11<br>passed the written exam within 90 days of successful completion of the clinical skills validation portion of the competency evaluation. [Refer to Tag 132 10A NCAC 13G .0403 (b) Qualifications of Medication Staff ]<br><br>5. Based on staff interviews and record reviews, the facility failed to assure 1 of 2 staff members (Staff B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry.[Refer to Tag 145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications]<br><br>6. Based on interviews and record reviews, the facility failed to assure 1 of 2 employees (Staff B) have a criminal background check before employment.[Refer to Tag 147 10A NCAC 13G. .0406 (a) (7) Other Staff Qualifications]<br><br>7. Based on observation and interview, the administrator failed to assure that 4 of 6 sampled residents (#2, #3, #4, and #5) were not left alone in the home without a staff member.[Refer to Tag 186 10A NCAC 13G .0601 (b) Management and other staff.]<br><br>8. Based on interview and record review the facility failed to ensure referral and follow-up to meet routine and acute health care needs of 1of 6 sampled residents who complained of a skin rash, sore buttocks and pain from long finger nails.[Refer to Tag 246 10A NCAC 13G .0902 (b) Health Care]<br><br>9. Based on observation and interviews the facility failed to assure a three-day supply of perishable food and a five-day supply of non-perishable food in the facility.[Refer to Tag 259 10A NCAC 13G .0904 (a) (4) Nutrition and Food Service] | C 185 | | |

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| C 185 | Continued From page 12<br><br>10. Based on observation, interview, and record review, the facility failed to assure the medications were administered as ordered by the licensed prescribed practitioner. [Refer to Tag 330 10A NCAC 13G .1004 (a) Medication Administration]<br><br>11. Based on observations and staff interviews, the facility failed to assure cleaning agents and other potentially hazardous substances, such as bleach, were stored separately and securely. [Refer to Tag 059 10A NCAC 13G ..0310 (b) Storage Areas]<br><br>12. Based on interviews and record reviews, the facility failed to assure upon employment 1 of 2 employees (Staff B) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the North Carolina Department of Health and Human Services Division of Public Health Epidemiology Section-TB Control. [Refer to Tag 140 10A NCAC 13G .0405 Test for Tuberculosis]<br><br>13. Based on observation and staff interview, the facility failed to maintain the building and electrical equipment, such as the facility's smoke alarms and clothes dryer, in a safe and operating condition. [Refer to Tag 102 10A NCAC 13G .0317 (a) Building Service Equipment]<br><br>14. Based on observations and interviews, the facility failed to assure a telephone was available for 6 of residents to make and receive calls. [Refer to Tag 299 10A NCAC 13G ..0906 (d) Other Resident Services]<br><br>15. Based on staff interviews and record reviews, the facility failed to obtain review of each | C 185 | | |

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| JONES FAMILY CARE HOME | 3620 BARWELL ROAD RALEIGH, NC 27610 |

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| C 185 | Continued From page 13<br><br>residents drug regimen by a licensed pharmacist, prescribing practitioner, or registered nurse (RN) for the provision of pharmaceutical care at least quarterly for 6 of 6 resident living in the facility. [Refer to Tag 375 10A NCAC 13G .1009 Pharmaceutical Reviews]<br><br>16. Based on interview and record review, the facility failed to provide personal care needs for 1 of 6 sampled residents (Resident #3) who could not care for himself. [Refer to Tag 242 10A NCAC 13G .0901(a) Personal Care and Supervision]<br><br>17. Based on observation, and interview, the facility failed to assure every resident was free of neglect. [Refer to Tag 914 G.S. 131D-21 (4) Resident's Rights]<br><br>DIRECTED PLAN OF CORRECTION<br><br>1. The facility shall develop a system to identify components and responsibilities for total operation of a family care home and shall be responsible to the Division of Health Service Regulation and the county department of social services. This is to begin immediately.<br><br>2. The facility shall develop policies and procedures to address administrative responsibilities for total operation of a family care home. Policies should address health, safety, and welfare of residents and be communicated to staff. This is to begin immediately.<br><br>3. The administrator is to develop and maintain interventions and implementation including effectiveness of interventions for the policies/procedures. This is to begin immediately. | C 185 | | |

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| C 185 | Continued From page 14<br><br>4. The administrator shall assure any co-administrator staff receives orientation to administrative policies/procedures.<br><br>5. The administrator is to provide training by a licensed health professional to co-administrator staff responsible for total operation of the family care home. Documentation of this training is to be maintained on file and to include information on the presenter, what was discussed, date and attendance.<br><br>6. The facility shall develop a quality assurance plan for the above.<br><br>THE DIRECTED PLAN OF CORRECTION SHALL NOT EXCEED October 30, 2009. | C 185 | | |
| C 186 | 10A NCAC 13G .0601 (b) Management And Other Staff<br><br>10A NCAC 13G .0601 Management And Other Staff<br><br>(b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used:<br>(1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at | C 186 | | |

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| C 186 | Continued From page 15<br>all times. When the administrator does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home;<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE A VIOLATION WITH A DIRECTED PLAN OF CORRECTION.<br><br>Based on observation and interview, the administrator failed to assure that 4 of 6 sampled residents (#2, #3, #4, and #5) were not left alone in the home without a staff member. The findings are:<br><br>When surveyors arrived at the home at 5: 00 p.m. on 10/6/09, there was a burgundy and white van parked in the drive way. There was no one outside at that time. When the surveyor knocked on the door, one resident looked out the window and opened the door. When asked about staff, they revealed staff (Staff A) had taken two residents to their doctor appointments and did not know when they would be back.<br><br>Observations and interviews on 10/6/09 at 5:05 p.m. revealed four residents (#2, #3, #4 and #5) had been left alone at the home with no staff present. There were three residents in one of the rooms. One of the residents was sitting in a wheelchair, one was sitting in a chair against the wall, and one was sitting at the back of a picnic styled table. A fourth resident joined the three residents and stated he had been sitting in a chair in his bedroom located in the back of the home. | C 186 | | |

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| C 186 | Continued From page 16<br><br>Confidential resident interviews revealed they have been left alone at the home before without a staff member and they took care of themselves. The residents stated that they have been left alone on several occasions and this was not the first time. One of the residents stated that they would walk to the local fire station if they needed help. During the same interview, the residents complained of discomfort due to the hot temperature in the home. Two of the residents stated they were hungry, and one asked if supper could be cooked.<br><br>When asked if they had a telephone to use to call someone, one resident stated that the telephone did not work. When the telephone was checked there was no dial tone. The home was observed to be hot and muggy. The residents stated their air conditioner was broken. Observations at this time revealed there was no fan in the room.<br><br>One of the residents left the room and went outside. The resident was observed walking away from the facility in the street, which was busy with two way traffic. The resident ' s back was to oncoming traffic. After returning to the facility, the resident asked for a telephone and stated she wanted to call the administrator. The resident stated the administrator was out of town but should return soon.<br><br>The local law enforcement was notified by the adult protective services unit on 10/6/09 at 5:45 p.m. When the local law enforcement arrived, they called the local emergency service unit to check the medical status of the residents since they had been left alone.<br><br>On 10/6/09 at 6:45 p.m., one of the residents | C 186 | | |

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| C 186 | Continued From page 17<br>informed emergency services that he wanted to go the local hospital to have his "painful buttocks" assessed and to get medication to reduce his "skin itching".<br><br>The resident who requested to go to the hospital on 10/6/09 at 6:45 p.m. stood up with assistance and dropped his pants to show his buttocks. The buttocks had a dark area near the scrotum. The resident ' s skin was peeling on his shoulders, arms and back.<br><br>Before the emergency vehicle left the facility with Resident #3, Staff A drove up in a white car with two residents at 7:00 p.m. Staff A got out of the car and asked Resident #3 why he was going to the hospital. The resident stated he was in pain and wanted the doctor to "look at his buttocks".<br><br>Interview with Staff A on 10/6/09 at 7:10 p.m. revealed she had to take two residents to their doctors appointments and the administrator was supposed to be back in town by 3:00 p.m. There no other explanation why the residents had been left alone.<br><br>Interview with the administrator on 10/7/09 at 2:30 p.m. revealed the residents should not have been left alone. It was not her preference, "a cab should have been called to pick the residents up from the doctor appointment and the Staff A should have returned to the home". The administrator stated that the residents were not bedbound and they could do things for themselves.<br><br>Telephone interview with one of the resident's physician on 10/13/09 at 2:35 p.m. revealed the resident is incapable of providing personal care and should not be left alone due to his mental | C 186 | | |

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| C 186 | Continued From page 18<br>status and diagnoses.<br><br>Telephone interview on 10/13/09 at 10:22 a.m. with another resident's primary physician revealed the resident has complained about being left alone for extended period of times.<br><br>Telephone interview on 10/14/09 at 8:40 a.m. with two of the resident's physician revealed it is his expectation that these residents are not be left alone.<br><br>Telephone interview on 10/14/09 at 9:10 a.m. with one of the resident's physician revealed it is his expectation that the resident is not left alone and is not capable of staying alone.<br><br>DIRECTED PLAN OF CORRECTION<br><br>1. The facility shall develop a system to identify components and responsibilities for total operation of a family care home and shall be responsible to the Division of Health Service Regulation and the county department of social services. This is to begin immediately.<br><br>2. The facility shall develop policies and procedures to address administrative responsibilities for total operation of a family care home. Policies should address health, safety, and welfare of residents and be communicated to staff. This is to begin immediately.<br><br>3. The administrator is to develop and maintain interventions and implementation including effectiveness of interventions for the policies/procedures. This is to begin immediately.<br><br>4. The administrator shall assure any | C 186 | | |

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| C 186 | Continued From page 19<br>co-administrator staff receives orientation to administrative policies/procedures.<br><br>5. The administrator is to provide training by a licensed health professional to co-administrator staff responsible for total operation of the family care home.<br>Documentation of this training is to be maintained on file and to include information on the presenter, what was discussed, date and attendance.<br><br>6. The facility shall develop a quality assurance plan for the above.<br><br>THE DIRECTED PLAN OF CORRECTION SHALL NOT EXCEED OCTOBER 30, 2009. | C 186 | | |
| C 207 | 10A NCAC 13G .0702(c)(4) Tuberculosis Test and Medical Examination<br><br>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination<br>(c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:<br>(4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the administrator or supervisor-in-charge shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs.<br><br>This Rule is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to contact the resident's physician or prescribing practioner for clarification of missing | C 207 | | |

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| C 207 | Continued From page 20<br>diet orders for 3 of 6 residents (Resident #2,#3,#4) sampled for review. The findings are:<br><br>1. Review of Resident #2's FL-2,dated 7/21/08, revealed diagnoses of schizophrenia paranoid type, history of polysubstance abuse,syphilis, gastroesophageal reflux disease, increased cholesterol and liver function tests, and status post myocardial infarction.<br><br>Record review of Resident #2's Resident Register revealed an admission date of 08/25/06. Resident #2's FL-2 revealed no documentation of a diet order.<br><br>Further review of the resident's record revealed no diet order.<br><br>Interview with the primary physician on 10/13/09 at 10:22 a.m. revealed his expectation would be for Resident #2 to receive a low sodium diet secondary to diagnoses of hypertension and would have clarified this with the facility if he had received a request from the facility. Further interview revealed on the last physician visit 9/23/09, the resident's blood pressure was 187/100.<br><br>Refer to the interview with administrator on 10/07/09 at 11:50 a.m.<br><br>2. Review of Resident #3's FL-2 dated 03/30/09 revealed diagnoses of seizure disorder, hypertension, paranoid schizophrenia, hyperlipidemia, and history of hepatitis C. Resident #3's FL-2 revealed no documentation of a diet order.<br><br>Review of the Resident Register dated 05/18/04 revealed an admission date of 05/18/04. | C 207 | | |

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| C 207 | Continued From page 21<br><br>Review of a FL-2 dated 3/12/09 revealed a diet order as low salt. The current FL-2 dated 3/30/09 revealed no diet order.<br><br>Refer to the interview with administrator on 10/07/09 at 11:50 a.m.<br><br>3. Review of Resident #4's FL-2 dated 05/11/09 revealed diagnoses of schizophrenia chronic paranoid, chronic left hip pain, personality disorder, benign prostate hypertrophy, hyperlipidemia, and history of seizure disorder. Resident #4's FL-2 revealed no documentation of a diet order.<br><br>Further review of the resident's record revealed no diet order.<br><br>Refer to the interview with administrator on 10/07/09 at 11:50 a.m.<br><br>Interview with the Administrator on 10/07/09 at 11:50 a.m. revealed she did not clarify the diet orders for Resident #2,#3 or #4 with the physician. The Administrator indicated she thought the physician ordered a regular diet when there was no documentation of diet orders on the FL-2's. | C 207 | | |
| C 242 | 10A NCAC 13G .0901(a) Personal Care and Supervision<br><br>10A NCAC 13G .0901 Personal Care and Supervision<br>(a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for | C 242 | | |

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| C 242 | Continued From page 22<br>themselves.<br><br>This Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide personal care needs for 1 of 6 sampled residents (Resident #3) who could not care for himself. The findings are:<br><br>Review of the resident register revealed Resident #3 was admitted to the facility 5/18/04. The current FL-2 dated 3/30/09 revealed diagnoses of seizure disorder, paranoid schizophrenia, history of motor vehicle accident injury, hyperlipidemia, hypertension and history of hepatitis C. Resident #3's care plan dated 5/1/09 revealed the resident needed supervision and limited assistance with grooming, bathing and dressing.<br><br>Interview with Staff A on 10/7/09 at 9:15 a.m. revealed the resident's family member usually cuts his nails. Further interview with Staff A revealed staff gives the resident a bath once a week.<br><br>Observation on 10/6/09 at 9:20 a.m. revealed Resident #3's sitting in a wheelchair. The resident ' s left hand was contracted toward the inside of the left arm. The hand was observed with fingernails about 1 inch long that were pressing into the palm of the resident's hand. Interview with the Resident at this time revealed he could not walk.<br><br>Further observation on 10/6/09 at 3:15 p.m. revealed Resident # 3's 10 fingernails were all extended approximately 1 inch beyond his nail beds. The resident indicated the staff cuts his fingernails since his arms and hands are contracted. The resident could not recall the last date his fingernails were cut. | C 242 | | |

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| C 242 | Continued From page 23<br><br>Record review of the hospital discharge summary dated 10/7/09 revealed the hospital staff observed the resident with poor hygiene, "molded underwear" and a skin decubitus of the left inner side of the buttocks. " The patient was in underwear that was caked with dried and wet urine, upon arrival " to a local hospital emergency department.<br><br>Confidential resident interview revealed he was feeling stressing out due to dressing another resident daily. He stated he dressed the resident for church every Sunday because if he did not it would not get done. It was stated that initially, is. Continued interview revealed the resident and staff expect for him to dress the resident daily.<br><br>Interview with the administrator on 10/7/09 at 2:40 p.m. revealed the Resident #3 is bathe once a week and his sister cuts his fingernails when she visits. The administrator indicated that the resident can do for himself.<br><br>Interview with the Administrator on 10/8/09 at 10:30 a.m. revealed that the residents are physically able to do things for themselves and they are expected to do for themselves. | C 242 | | |
| C 243 | 10A NCAC 13G .0901(b) Personal Care and Supervision<br><br>10A NCAC 13G .0901 Personal Care And Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE A VIOLATION WITH A | C 243 | | |

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| C 243 | Continued From page 24<br>DIRECTED PLAN OF CORRECTION.<br><br>Based on observations, interviews and record review, the facility failed to provide supervision for 4 of 4 residents (#2, #3, #4 and #6) who were left unsupervised, waiting for transportation back to the facility, outside of a local community building on three known occasions (7/30/09, 8/5/09 and 10/6/09). The findings are:<br><br>1. A confidential interview revealed on 7/30/09 at 5:00 p.m. three residents were waiting outside a local community building for transportation back to their facility. The three residents waited 3 hours and fifty minutes after their day program ended at 4:00 p.m.<br><br>Review of the incident report from the local community center staff revealed the facility was called on 7/30/09 at 5:50 p.m. A resident answered the telephone and stated there was no staff present at the home.<br><br>At 6:00 p.m. on 7/30/09, the home was called and a staff person (Staff A) stated the usual driver had been arrested and someone was on the way.<br><br>At 6:55 p.m. on 7/30/09, the residents were still waiting and the home was called again. Staff A stated a second driver had run out of gas and a third driver was on the way and would be driving a gray Cherokee Jeep.<br><br>The person who completed the incident report dated 7/30/09 revealed the police were called because of the concern for the welfare of the residents. It was reported that one resident was in a wheelchair, one walked with a cane and the other resident was assisting the resident in the wheelchair. The residents were picked up by an | C 243 | | |

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|---|---|
| JONES FAMILY CARE HOME | 3620 BARWELL ROAD RALEIGH, NC 27610 |

| (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 |
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| C 243 | Continued From page 25<br><br>individual, that none of the residents knew, in a four by four jeep at 7:50 p.m. Continued interview revealed the residents were " packed in the back seat of the jeep and that one resident had to hold the wheelchair in his lap".<br><br>Telephone interview on 10/7/09 at 8:50 a.m., with the police officer on duty 7/30/09, revealed the local police department was notified 3 or 4 "disabled men" were waiting for a ride outside the local community center. The men were observed in front of the building and indicated they were waiting for transportation. The officer reported a small vehicle arrived and the men had difficulty getting in the vehicle with the wheelchair and cane because of the vehicle's size. The officer reported the driver indicated he was a friend of the regular driver and was paid to pick the men up. The local police officer reported that he was concerned for "the welfare and well being of the disabled men" that they may have been abandoned by the facility.<br><br>Interview with the Administrator on 10/8/09 at 10:15 a.m. regarding the incident of 7/30/09 revealed three residents waited for transportation from the local community center. The administrator stated she sent a taxi cab for the residents. When asked, the administrator did not remember the time the taxi cab was called to go to pick up the residents at the community center. She stated that the taxi cab had picked up the wrong residents and transported these individuals to the home. Once the taxi cab arrived at the home, the taxi driver was told by the former supervisor in charge the residents in the taxi did not live at the home. The administrator had no explanation to why the community center was not called when it was discovered that the wrong residents were brought to the home. When | C 243 | | |

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| C 243 | Continued From page 26<br>asked, what vehicle were the residents picked up in, the administrator revealed a four by four jeep owned by the former supervisor in charge.<br><br>2. A confidential interview with staff of the local community center revealed that on 8/5/09 two residents (#2, #4) were left waiting for transportation after the day program had ended at 4:00 p.m. The interviewee revealed that the home was called at 4:30 p.m., and there was no answer. The home was called again at 4:45 p.m., and still there was no answer. According to interview, the administrator ' s cell phone was called at 5:15 p.m. At that time, the administrator gave instructions for the residents to go across the street to the YWCA (Young Women's Christian Association) and wait for transportation. The residents walked across a busy two-way street to the YWCA.<br><br>Confidential interview with YWCA staff revealed they were called by staff of a local community center on 8/5/09 around 5:00 p.m. The Center ' s staff revealed the family care home owner instructed the residents to go to the YWCA because she knew staff at the YWCA and the YWCA would not mind if the residents were there. The YWCA staff reported they did not receive a call from the facility's administrator regarding the residents waiting at the YWCA for transportation.<br><br>Interview with the administrator on 10/8/09 at 10:30 a.m. regarding the 8/5/09 incident revealed she instructed the residents to go across the street to the YWCA and wait for transportation. The administrator revealed she received a called from the YWCA asking why the residents were there. The administrator further stated that the YWCA was a public safe haven and the residents | C 243 | | |

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| C 243 | Continued From page 27<br>could go there. The administrator could not state how long the residents were waiting at the YWCA, but they were picked up.<br><br>3. Observations on 10/6/09 at 4:15 p.m. revealed Residents #2, 3#, #4 and #6 were waiting outside the community center to be transported to the facility.<br><br>Confidential interview with staff of the local community program revealed residents are frequently left waiting for transportation to their home after the day program has ended, up to three to four times a week.<br><br>At 4:30 p.m. on 10/6/09, Staff B was observed picking the residents up and transported them to the facility.<br><br>4. Based on observation and interview, the administrator failed to assure that 4 of 6 sampled residents (#2, #3, #4, and #5) were not left alone in the home without a staff member. Refer to tag C186 [10A NCAC 13G .0601(b) Management and other staff].<br><br>DIRECTED PLAN OF CORRECTION<br><br>1. The facility shall provide supervision of residents in accordance with residents ' assessed needs and current symptoms to ensure the health, safety and welfare of all residents are not endangered. This is to begin IMMEDIATELY.<br><br>2. The facility shall develop and implement procedures to ensure residents are not left alone in the facility or at other locations; and this includes waiting for transportation. This is to begin IMMEDIATELY. | C 243 | | |

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| C 243 | Continued From page 28<br><br>3. The facility shall assure development of individualized plans of care for resident supervision including strategies to prevent leaving residents unsupervised and alone.<br>This is to begin IMMEDIATELY.<br><br>4. The facility shall assure all staff receive orientation to any plans of care implemented as the result of resident assessments.<br><br>5. The facility is to provide training by a licensed health professional to all staff responsible for providing resident supervision. Documentation of this training is to be maintained on file and to include information on the presenter, what was discussed, date and attendance.<br><br>6. The facility shall develop a quality assurance plan for the above.<br><br>THE DIRECTED PLAN OF CORRECTION SHALL NOT EXCEED OCTOBER 30, 2009. | C 243 | | |
| C 246 | 10A NCAC 13G .0902(b) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION.<br><br>Based on interview and record review, the facility failed to ensure referral and follow-up to meet routine and acute health care needs of 1 of 6 sampled residents who complained of a skin rash, sore buttocks and pain from long finger nails (Resident #3). The findings are: | C 246 | | |

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| C 246 | Continued From page 29<br><br>Review of the resident register revealed Resident #3 was admitted to the facility 5/18/04. The current FL-2 dated 3/30/09 revealed diagnoses of seizure disorder, paranoid schizophrenia, history of motor vehicle accident injury, hyperlipidemia, hypertension and history of hepatitis C. Resident #3's care plan dated 5/1/09 revealed the resident needed supervision and limited assistance with grooming, bathing and dressing.<br><br>Interview with Staff A on 10/7/09 at 9:15 a.m. revealed the resident's family member usually cuts his nails. Further interview with Staff A revealed staff give the resident a bath once a week and she was not aware of the complaints of a sore on the resident's buttocks.<br><br>Confidential resident interview revealed Resident #3 ' s sleep is disturbed by leg pain, groin skin peeling, and an itchy back rash. The resident stated Resident #3 frequently asks the other residents to scratch the rash using a cane. The resident revealed Resident #3 has now developed a " buttocks decubitus " . The resident revealed Resident #3 is very proud and tries to bathe most days without assistance. The resident does not feel Resident #3 can give himself a good sponge bath since his arms and hands are contracted.<br><br>Observation on 10/6/09 at 9:20 a.m. revealed Resident #3's left hand was contracted toward the inside of the left arm. The hand was observed with fingernails about 1 inch long that were pressing into the palm of the resident's hand.<br><br>Further observation on 10/6/09 at 3:15 p.m. revealed Resident # 3's 10 fingernails were all extended approximately 1 inch beyond his nail | C 246 | | |

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| C 246 | Continued From page 30 | C 246 | | |

beds. The resident indicated the staff cuts his fingernails since his arms and hands are contracted. The resident could not recall the last date his fingernails were cut.

Interview with Resident #3 on 10/6/09 at 2:30 p.m. revealed the left hand was "sore and hurt really bad". The resident indicated that he could not clean the hand because "it hurts". The resident stated that his family member would cut his nails when she visits, but she had not visited in about two months.

Observation on 10/6/09 at 7:10 p.m. revealed Resident # 3 informing emergency medical technicians he wanted to go to a local hospital for assessment of his groin area, skin peeling and itching, and a painful buttocks sore.

Observation on 10/6/09 at 7:25 p.m. revealed Resident #3 crying out in pain as he was being transferred onto an emergency stretcher. The resident indicated he could not lie flat and bend his right knee without pain.

Resident #3 revealed he has requested staff to take him to the physician for his buttocks but that has not happened. Observations on 10/6/09 at 6:45 p.m. revealed the resident's buttocks had a dark area near the scrotum. The resident's skin was peeling on his shoulders, arms and back.

Interview on 10/7/09 at 9:30 a.m. with the Administrator revealed Resident #3 stayed overnight at a local hospital. The Administrator reported the resident has a diaper rash and will need medical follow up. Further interview revealed a recent skin assessment had not been completed on the resident, but she had been planning to schedule the appointment. She

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| C 246 | Continued From page 31<br>revealed the resident may have gone to the hospital on 10/6/09 since he enjoys the socialization.<br><br>Review of a local hospital emergency department nursing assessment revealed, " Pt ' s [Patient ' s] skin is peeling all over. Upper thighs, between his legs, buttocks and scrotal area affected worse with areas of erythema and raw looking skin " .<br><br>Record review of the hospital discharge summary dated 10/7/09 revealed the hospital staff observed the resident with poor hygiene, "molded underwear" and a skin decubitus of the left inner side of the buttocks. " The patient was in underwear that was caked with dried and wet urine, upon arrival " to a local hospital emergency department.<br><br>Confidential telephone interview revealed Resident #3 was last seen by his primary physician on 7/13/09 and there was no complaint of the buttocks or skin itching.<br><br>Interview with the administrator on 10/7/09 at 2:40 p.m. revealed the resident is given a bath once a week and his family member cuts his fingernails. The administrator stated that Resident #3 can do for him self and she was not aware of the complaints of sores on his buttocks. The administrator stated that Resident #3 can not be taken seriously when he complains.<br><br>THE DIRECTED DATE OF CORRECTION SHALL NOT EXCEED OCTOBER 30, 2009. | C 246 | | |
| C 259 | 10A NCAC 13G .0904(a)(4) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service | C 259 | | |

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| C 259 | Continued From page 32<br>(a) Food Procurement and Safety in Family Care Homes:<br>(4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets.<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION<br><br>Based on observation and interviews, the facility failed to assure a three-day supply of perishable food and a five-day supply of non-perishable food in the facility. The findings are:<br><br>Observation on 10/6/09 at 8:30 a.m. revealed package of chicken gizzards/hearts with a sell by date of 10/5/09. Further observation revealed two pitchers of liquid, 1 package of sliced center cut ham in the refrigerator drawer, miscellaneous condiments half of a jar of jelly, mayonnaise inside the door of the refrigerator and 6 single eggs on top of a 1 ½ dozen egg container on the bottom shelf of the refrigerator.<br><br>Observation of the freezer section of the refrigerator on 10/6/09 at 8:40 a.m. revealed a box with one hot pocket, and 2 pint sized containers of ice cream.<br><br>Observation of the freezer chest located in the living room on 10/6/09 at 8:40 a.m. revealed 1 ziploc bag of fish.<br><br>Observation of the cabinets and pantry closet revealed the following:<br>3 boxes of cake mix in the cabinet<br>1-16 oz open box of mashed potatoes in the cabinet | C 259 | | |

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| C 259 | Continued From page 33 | C 259 | | |

1 can of clam chowder in the cabinet
3 boxes of pancake mix in the pantry,
1 ten pound bag of white potatoes in the pantry
open packs of noodles in the pantry
4 boxes of cornbread mix in the pantry
3 open jars of peanut butter in the pantry
1 bag of pork rinds in the pantry
2 full bottles of syrup and 2 empty bottles of syrup in the pantry

When the pantry door was open the live in cat entered and began eating particles off the bottom of the floor of the pantry. One of the Resident's asked if the cat should be removed from the pantry.

Confidential resident interview revealed breakfast was not served on 10/6/09, and breakfast is usually not served in the mornings. Continued interview revealed on the weekends the residents get cold cereal with milk for breakfast and a sandwich for lunch.

Confidential resident interview revealed the Administrator sends Staff A money for food purchases. During the same interview it was indicated that residents are expected to give money toward the extra food costs.

Confidential resident interview revealed residents have pitched in and help buy food and snacks.

Confidential interview with staff of the local community center revealed that only lunch is served at the center and residents from the family care home have arrived to the local day program and requested food for breakfast.

Interview with Staff A on 10/6/09 at 9:00 a.m. revealed the administrator will give her money to

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| C 259 | Continued From page 34<br>buy groceries and she has been waiting for the administrator to send the money. It was further revealed that food was thrown out on 9/23/09 because there was no electricity and water in facility at the time.<br><br>Observation of menus posted on the pantry door dated 2002 on 10/6/09 revealed the residents should have received for Breakfast: 2 slices Cinnamon Raisin Toast, and Applesauce, Lunch: (when not at center) should have been sliced turkey on sub roll, shredded lettuce, sliced tomato and pineapple chunks, Dinner: should have been sliced roast port, steamed rice cornbread sauce, baked sweet potatoes, collard and Snack - triscuit crackers, orange wedges.<br><br>Observation on 10/6/09 at 8:00 p.m. Staff A served two hot dogs in a bun, a bowl of pork and beans and cooked green beans to six residents.<br><br>Two of the residents where observed picking the bowl of pork beans and tilted the bowls toward their faces to eat without spoons. When Staff A asked the residents why they were doing that the residents stated they were very hungry.<br><br>The menu for 10/7/09 revealed the residents should have received for breakfast: ½ cup of oatmeal with jelly, grapefruit half, 1 slice toast and jelly, Lunch: (when not at center) should have received cheese pizza slice, pizza crust breadstick, tossed salad with fat free dressing and chilled peaches. Dinner: should have received country style steak with ½ cup noodles, roll, mixed vegetables, and pineapple chunks, Snack: residents should have received granola bar and grape juice.<br><br>Interview with the administrator on 10/8/09 at | C 259 | | |

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| C 259 | Continued From page 35<br><br>10:30 a.m. revealed she instructed the staff to throw out the food in the freezer and refrigerator, however, the administrator could not reveal the date they were instructed to do so. It was indicated that groceries are bought monthly and perishable items are brought weekly. The administrator had no explanation to why there was no three day perishable food supply and five day non-perishable food supply.<br><br>THE DIRECTED DATE OF CORRECTION SHALL NOT EXCEED OCTOBER 30, 2009. | C 259 | | |
| C 299 | 10A NCAC 13G .0906 (d) Other Resident Services<br><br>10A NCAC 13G .0906 Other Resident Services<br><br>(d) Telephone.<br>(1) A telephone must be available in a location providing privacy for residents to make and receive a reasonable number of calls of a reasonable length;<br>(2) A pay station telephone is not acceptable for local calls; and<br>(3) It is not the home's obligation to pay for a resident's toll calls.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to assure a telephone was available for 6 of residents to make and receive calls. The findings are:<br><br>Confidential resident interview revealed the resident's telephone located in the facility's office was not working. The resident did not know how long the telephone had not been working. The | C 299 | | |

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| C 299 | Continued From page 36<br>resident revealed they needed a working phone to contact family and friends and take care of their business issues.<br><br>Confidential interview with another resident revealed this is not the first time the facility's phone has not worked. The resident indicated this could be a safety hazard particularly when the residents are left alone at the facility. The resident revealed earlier this summer she needed to make a personal call and the telephone was not working. The resident revealed they walked alone to the nearby fire station to use the telephone.<br><br>Confidential resident interview revealed one of the residents would have to walk to the fire station for help in an emergency situation, the facility did not have a working phone and staff was not present.<br><br>Observation on 10/6/08 at 5:20 p.m. a telephone was located on a table in the facility's office. A call could not be placed since the telephone had no dial tone.<br><br>Observation on 10/6/9 at 7:20 p.m. revealed Staff A attempted to use the facility's telephone and found it not working. Staff A indicated she would find a second phone for the residents to use. Staff A tried to use a second phone in the office and discovered it did not work. Staff A indicated the residents could always use the phone in her bedroom, but she revealed her bedroom door is often locked most of the day. | C 299 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration | C 330 | | |

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| C 330 | Continued From page 37<br>(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>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION<br><br>Based on observations, interview and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 5 of 6 residents (#1, #2, #3, #5, and #6). The findings are:<br><br>1. Record review revealed Resident #1's diagnoses on the current FL-2 dated 02/09/09 included psychotic disorder, alcohol abuse, substance abuse and cerebral vascular accident. Further review of the FL-2 revealed medication orders for Zyprexa 10mg three tablets at bedtime and Motrin 600mg every 8 hours as needed. (Zyprexa is used to treat the symptoms of schizophrenia and Motrin is used to relieve pain.)<br><br>Record review revealed no MAR for Resident #1 for the month of October 2009.<br><br>Review of the August 2009 and September 2009 Medication Administration Records (MAR) revealed Zyprexa 10mg three tablets at bedtime was documented as given at 8:00 p.m. There was no documentation of administration of Motrin.<br><br>Further review of the August 2009 and | C 330 | | |

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| JONES FAMILY CARE HOME | 3620 BARWELL ROAD RALEIGH, NC 27610 |

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| C 330 | Continued From page 38<br><br>September 2009 Medication Administration Records (MAR) revealed Colace 100 mg one tablet twice a day was documented as given at 8:00 a.m. and 8:00 p.m. Review of the resident's record revealed no order to administer Colace.<br><br>Review of the information on the medication label revealed that 90 tablets of Zyprexa 10 mg. were dispensed on 08/05/09 (30 days supply). Dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed the only dispensing of the Zyprexa was on 08/05/09. Observation at 8:00 p.m. on 10/06/09 revealed 23 tablets of Zyprexa 10 mg. were still available for administration.<br><br>Telephone interview with the physician on 10/14/09 at 8:40 a.m. revealed it is expected that medications are given as ordered.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>2. Record review revealed Resident #2's diagnoses on the current FL-2 dated 07/21/08 included schizophrenia paranoid type, gastro esophageal reflux disease, hypertension, elevated cholesterol, elevated liver function test, status post myocardial infarction, history of polysubstance abuse, human immunodeficiency virus positive and history of syphilis.<br><br>Further review of FL-2 revealed medication orders for Risperdal 3mg at bedtime (Risperdal is used to treat the symptoms of schizophrenia), Toprol XL 100mg daily (Toprol is used to treat high blood pressure), Zoloft 50mg daily (Zoloft is | C 330 | | |

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| C 330 | Continued From page 39<br><br>used to treat depression, obsessive-compulsive disorder), Loratadine 10mg daily (Loratadine is used to temporarily relieve the symptoms of hay fever), Pravachol 20mg daily (Pravachol is used to decrease the amount of cholesterol), Lotrel 10-20mg daily (Lotrel is used to treat high blood pressure), Epzicam 600mg daily (Epzicam is used in combination with other medications to treat human immunodeficiency virus infection), Tekturna 300mg daily (Tekturna is used to treat human immunodeficiency virus infection), Kaletra 200-50mg two tablets twice a day (Kaletra is used with other antiviral medications to treat human immunodeficiency virus infection), Aspirin 81mg daily (Aspirin is used to prevent strokes and heart attacks), Risperdal Consta 50mg IM every 2 weeks (Risperdal is used to treat the symptoms of schizophrenia), Proctocort one suppository three times a day as needed (Proctocort is used for itching and skin irritation) and Albuterol 90mcg inhaler 2 puffs every 6 hours as needed (Albuterol is used to treat and prevent wheezing).<br><br>Record review revealed a subsequent order dated 7/21/09 for Zoloft 100mg daily.<br><br>Interview with the resident on 10/6/09 at 3:30 p.m. revealed she did not receive her medications this morning. It was also stated that she does not get her medications 1 to 3 times a week.<br><br>Review of the information on the medication label revealed that 30 tablets of Zoloft 100 mg. were dispensed on 09/04/09 (30 days supply). Dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed the only dispensing of the Zoloft 100 mg was on 08/13/09 (30 days supply) and 09/04/09 (30 days supply). Observation at 8:00 p.m.on 10/06/09 revealed 24 | C 330 | | |

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| C 330 | Continued From page 40 | C 330 | | |

tablets of Zoloft 100 mg. were still available for administration.

Review of the information on the medication label revealed that 30 tablets of Epzicam 600-300 mg were dispensed on 09/01/09 (30 days supply). Dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed the only dispensing of the Epzicam 600-300 mg was on 08/05/09 (30 days supply) and 09/01/09 (30 days supply). Observation at 8:00 p.m. on 10/06/09 revealed 24 tablets of Epzicam 600-300 mg were still available for administration.

Review of the information on the medication label revealed that 30 tablets of Risperdal 3 mg. were dispensed on 09/04/09 (30 days supply). Dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed the only dispensing of the Risperdal 3 mg. was on 08/13/09 (30 days supply) and 09/04/09 (30 days supply). Observation at 8:00 p.m. on 10/06/09 revealed 21 tablets of Risperdal 3 mg. were still available for administration.

Review of the information on the medication label revealed that 30 tablets of Tekturna 300 mg. were dispensed on 09/04/09 (30 days supply). Dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed the only dispensing of the Tekturna 300 mg was on 08/05/09 (30 days supply) and 09/04/09 (30 days supply). Observation at 8:00 p.m. on 10/06/09 revealed 20 tablets of Tekturna 300 mg were still available for administration.

Review of the information on the medication label revealed that 120 tablets of Kaletra 200-50 mg. were dispensed on 09/01/09 (30 days supply). Dispensing records provided from the pharmacy

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| C 330 | Continued From page 41<br>for 08/01/09 through 09/30/09 revealed the only dispensing of the Kaletra 200-50 mg.was on 08/05/09 (30 days supply) and 09/01/09 (30 days supply). Observation at 8:00 p.m.on 10/06/09 revealed 2 tablets of Kaletra 200-50 mg. were still available for administration.<br><br>Review of the information on the medication label revealed that 30 tablets of Toprol XL 100 mg. were dispensed on 09/01/09 (30 days supply). Dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed the only dispensing of the Toprol XL 100 mg. was on 08/05/09 (30 days supply) and 09/01/09 (30 days supply). Observation at 8:00 p.m.on 10/06/09 revealed 11 tablets of Toprol XL 100 mg. were still available for administration.<br><br>Review of the information on the medication label revealed that 30 tablets of Lotrel 10-20 mg. were dispensed on 09/01/09 (30 days supply). Dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed the only dispensing of the Lotrel 10-20 mg. was on 08/05/09 (30 days supply) and 09/01/09 (30 days supply). Observation at 8:00 p.m.on 10/06/09 revealed 6 tablets of Lotrel 10-20 mg. were still available for administration.<br><br>Interview with the emergency services on 10/6/09 at 7:10 p.m. revealed the resident stated she had not had medicine since 10/5/09.<br><br>Telephone interview with the primary care physician on 10/13/09 at 10:20 a.m. revealed the facility does not communicate with him in person or by telephone. The provider reported being very concerned about the resident's depression. For over one year, the depression has worsened since admission to the family care home. It was | C 330 | | |

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| C 330 | Continued From page 42<br>stated that medications should be given as ordered; especially her hypertension and depression medications. The physician stated that on the last visit on 9/23/09 the resident's blood pressure was 187/100.<br><br>Telephone interview with the mental health provider on 10/13/09 at 11:00 a.m. revealed he would expect the resident to receive medications as ordered. Missing doses may result in precipitating symptoms and require hospitalization.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>3. Record review revealed Resident #3's diagnoses on the current FL-2 dated 03/30/09 included seizure disorder, paranoid schizophrenia, hypertension, hyperlipidemia and history of hepatitis C.<br><br>Further review of the FL-2 revealed medication orders of Lisinopril/Hct 12.5/10 one tablet daily, Abilify 200mg at bedtime, Colace 100mg daily, Topomax 100 mg. every morning and 150 mg. every evening (Topiramate is used alone or with other medications to treat certain types of seizures in people who have epilepsy), Enteric Coated Aspirin 81 mg. daily, Calcium 600 mg. with Vitamin D400 units twice daily (Calcium is a dietary supplement used when the amount of calcium taken in the diet is not enough), Mirtazapine 30 mg. at bedtime (Mirtazapine is used to relieve migraine and tension headaches), Simvastatin 40 mg. every evening, Pentoxitylline 400 mg. twice a day, Dermac and Tylenol. | C 330 | | |

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| C 330 | Continued From page 43<br><br>Record review revealed a subsequent order dated 4/29/09 for Prilosec 20 mg. at bedtime (Prilosec is used alone or with other medications to treat ulcers).<br><br>Observation on 10/6/09 at 8:05 p.m. of Resident # 3's medications revealed the following information.<br><br>Review of the label for Topomax 100 mg. revealed Topomax 100 mg. 135 tablets (90 days supply) were dispensed on 03/20/09. Observation at 8:00 p.m.on 10/06/09 revealed 225 tablets of Topomax 100 mg. were still available for administration.<br><br>Review of the label for Prilosec 20 mg. revealed Prilosec 20 mg. 30 tablets (30 days supply) were dispensed on 03/18/09. Observation at 8:00 p.m.on 10/06/09 revealed 28 tablets of Prilosec 20 mg. were still available for administration.<br><br>Review of the label for Mirtazapine revealed Mirtazapine 30 mg. 90 tablets (90 days supply) were dispensed on 07/01/09. Observation at 8:00 p.m.on 10/06/09 revealed 53 tablets of Mirtazapine 30 mg. were still available for administration.<br><br>Review of the label for Calcium 600 mg with Vitamin D 400 units revealed Calcium 600 mg with Vitamin D 400 units. 180 tablets (90 days supply) were dispensed on 08/21/09. Observation at 8:00 p.m.on 10/06/09 revealed 180 tablets of Calcium 600 mg with Vitamin D 400 units were still available for administration, for the bottle had not been opened.<br><br>Interview with Resident #3 on 10/6/09 at 3:00 pm | C 330 | | |

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revealed the staff did not give him any medications on 10/6/09 and will often not have time to give medications in the mornings because Staff A wakes up late. The resident revealed he should receive heart medication, seizure pill, and nerve medication.

Interview on 10/13/09 at 12:10 p.m. with Resident #3's physician who treats his seizure disorder revealed it is his expectation that the resident receives his medications as ordered.

Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m.and 8:15 p.m.

Refer to interview with administrator dated 10/7/09 at 10:30 a.m.

4. Record review of Resident # 5's FL-2 dated 1/22/09 revealed diagnoses of mild mental retardation, hard of hearing, legally blind, depression and human immunodeficiency virus, schizophrenia, chronic paranoid, personality disorder, history of seizure disorder, benign prostate hypertrophy, hyperlipidemia, and chronic left hip pain.

A. Review of the same FL-2 revealed an order for Sustiva 600 mg. at bedtime. (Sustiva is used with other medications to treat human immunodeficiency virus (HIV) infection.) Review of the 08/09 and 09/09 medication administration records revealed the medication was documented as administered once daily at bedtime. Record review revealed there were no 10/09 medication administration records.

Observation at 8:05 p.m. on 10/06/09 revealed 10 tablets of Sustiva 600 mg. were still available for administration.

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| C 330 | Continued From page 45<br><br>Review of the information on the medication label revealed that 30 tablets of Sustiva 600 mg. were dispensed on 9/1/09 (30 days supply). Review of dispensing records provided from the pharmacy for 08/01/09 through 09/30/09 revealed 30 tablets of Sustiva were dispensed on 08/06/09 and 09/01/09.<br><br>Telephone interview with the primary provider on 10/13/09 at 2:35 p.m. revealed it is expected that medications are administered as ordered. Interview revealed the resident is incapable of self-administration of medications.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>B. Review of the FL-2 dated 01/22/09 revealed an order for Lexapro 10 mg. once daily. (Lexapro is used to treat depression and generalized anxiety disorder)<br><br>Review of the 08/09 and 09/09 medication administration records revealed the Lexapro was documented as administered once daily at bedtime. Record review revealed there were no 10/09 medication administration records.<br><br>Observation at 8:05 p.m. on 10/06/09 revealed 30 tablets of Lexapro 10 mg. were still available for administration.<br><br>Review of the information on the medication label revealed 30 tablets of Lexapro 10 mg. were dispensed on 9/1/09 (30 days supply). Review of dispensing records provided from the pharmacy | C 330 | | |

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| C 330 | Continued From page 46<br>for 08/01/09 through 09/30/09 revealed 30 tablets of Lexapro 10 mg. were dispensed on 08/05/09 and 09/01/09.<br><br>Telephone interview with the primary provider on 10/13/09 at 2:35 p.m. revealed it is expected that medications are administered as ordered. Interview revealed the resident is incapable of self-administration of medications.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>5. Record review of Resident #6's FL-2 dated 3/14/09 revealed diagnoses of Bipolar Disorder, Depression, and Resolved Dependency.<br><br>A. Observation at 8:05 p.m. on 10/06/09 of medications on hand revealed a vial of Propranolol available for administration. Observation at 8:05 p.m. on 10/6/09 revealed 8.5 tablets were still available for administration.<br><br>Review of the information on the medication label revealed the Propranolol 20 mg. ½ tablet twice daily was to be administered and 30 tablets of Propranolol 20 mg were dispensed on 7/27/09 (30 day supply). Review of dispensing records from the pharmacy for 07/01/09 through 10/13/09 revealed the only dispensing for the Propranolol was on 7/27/09.<br><br>Record review revealed no orders for Propranolol. Review of the 08/09 and 09/09 medication administration records revealed no entry of Propranolol. (Propranolol is prescribed for high blood pressure and fast heart rate.) | C 330 | | |

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| C 330 | Continued From page 47<br>Record review revealed there were no 10/09 medication administration records.<br><br>Information provided from the pharmacy revealed a prescription was written on 07/20/09 for Propranolol 20 mg. ½ tablet twice daily and 30 tablets were dispensed on 07/27/09.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>Telephone interview with the physician on 10/14/09 at 8:40 a.m. revealed it is expected that medications for the resident are administered as ordered.<br><br>B. Review of the 03/14/09 FL-2 revealed an order for Lithium Carbonate 300 mg. 2 tablets at bedtime. (Lithium is used to treat and prevent episodes of mania)<br><br>Review of the medication administration records for 08/09 and 09/09 revealed documentation that Lithium Carbonate 300 mg 2 tablets at bedtime was administered. Record review revealed no 10/09 medication administration records available.<br><br>Observation at 8:05 p.m. on 10/06/09 revealed an empty vial of Lithium Carbonate.<br><br>Review of the information on the medication label revealed 60 tablets of Lithium Carbonate 300 mg. were dispensed on 06/22/09 (30 days supply). Dispensing records provided from the pharmacy revealed only 30 tablets of Lithium Carbonate 450 mg. were dispensed from 07/01/09 thorough | C 330 | | |

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| C 330 | Continued From page 48<br>10/06/09.<br><br>Interview with the pharmacist on 10/15/09 revealed Lithium 300 mg. was dispensed on 08/18/09, 08/27/09 and 09/05/09, but were not picked up for the resident.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>Telephone interview with the physician on 10/14/09 at 8:40 a.m. revealed it is expected that medications for the resident are administered as ordered.<br><br>C. Review of the 03/14/09 FL-2 revealed an order for Depakote 500 mg 1 by mouth twice daily. (Depakote is used alone or with other medications to treat certain types of seizures.) Record review revealed no other orders in the resident's record for Depakote.<br><br>Review of the 08/09 and 09/09 medication administration records revealed documentation that Depakote 500 mg. was administered twice daily. Record review revealed there were no 10/09 medication administration records.<br><br>Observation at 8:05 p.m. on 10/06/09 of medications on hand revealed an empty vial of Depakote 250 mg. Review of the medication label revealed directions for Depakote 250 mg.2 tablets in the morning and 3 tablets at bedtime.<br><br>Review of dispensing records from the pharmacy for 07/01/09 through 10/06/09 revealed only 150 tablets of Depakote 250 mg. had been | C 330 | | |

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| C 330 | Continued From page 49 | C 330 | | |

dispensed. Information from the pharmacy revealed there was a prescription dated 07/20/09 for Depakote 250 mg. 2 tablets in the morning and 3 tablets in the evening.

Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.

Refer to interview with administrator dated 10/7/09 at 10:30 a.m.

Telephone interview with the physician on 10/14/09 at 8:40 a.m. revealed it is expected that medications for the resident are administered as ordered.

D. Observation at 8:05 p.m. on 10/06/09 of medications on hand revealed an empty vial of Lorazepam 2 mg. Review of information on the medication label revealed 60 tablets of Lorazepam 2 mg were dispensed on 7/27/09.

Review of the 09/09 medication administration record revealed the resident was receiving Lorazepam 2 mg at bedtime.(Lorazepam is used to relieve anxiety). Record review revealed there was no 10/09 medication administration record.

Record review revealed there was no order for Lorazepam in the resident's record.

Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.

Refer to interview with administrator dated 10/7/09 at 10:30 a.m.

Telephone interview with the physician on 10/14/09 at 8:40 a.m. revealed it is expected that medications for the resident are administered as

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| C 330 | Continued From page 50<br>ordered.<br><br>E. Observation at 8:05 p.m. on 10/06/09 of medications on hand revealed an empty vial of Lisinopril 10 mg. Review of the information on the medication label revealed that 30 tablets of Lisinopril 10 mg were dispensed on 6/9/09 (30 day supply).<br><br>Review of the 09/09 medication administration record revealed documentation of Lisinopril 10 mg every day administered. (Lisinopril is prescribed to treat high blood pressure.)<br><br>Record review revealed there was no 10/09 medication administration record.<br>Interview with a staff at the pharmacy on 10/12/09 revealed 30 tablets (30 days supply) of Lisinopril 10 mg. was dispensed on 06/09/09 and 07/01/09.<br><br>Review of dispensing information from the pharmacy revealed a prescription was obtained on 05/29/09 for Lisinopril 10 mg.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>F. Observation at 8:05 pm on 10/06/09 of medications on hand revealed an empty vial of Benztropine 0.5 mg.<br><br>Review of the directions on the medication label revealed Benztropine 0.5 mg. was to be administered three times daily and 90 tablets of were dispensed on 7/27/09 (30 day supply)<br><br>Review of dispensing records from the pharmacy | C 330 | | |

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| C 330 | Continued From page 51<br>for 07/01/09 through 10/06/09 revealed the only dispensing of the Benztropine was on 07/27/09.<br><br>Review of the 09/09 medication administration record revealed documentation that Benztropine (Cogentin) 0.5 mg was administered three times a day. (Cogentin is used to treat the symptoms of Parkinson's disease and tremors). Record review revealed there was no 10/09 medication administration record.<br><br>Information from the pharmacy revealed a prescription for Benztropine 0.5 mg. three times daily was obtained on 07/20/09.<br><br>Refer to interview with supervisor in charge dated 10/6/09 at 8:00 p.m. and 8:15 p.m.<br><br>Refer to interview with administrator dated 10/7/09 at 10:30 a.m.<br><br>---<br><br>Interview on 10/6/09 at 8:00 p.m. with the Supervisor in Charge (SIC) revealed she had not completed the residents' October 2009 Medication Administration Records (MAR). The SIC stated she was administering October medications based on the September 2009 MAR and medication labels.<br><br>Interview on 10/6/09 at 8:15 p.m. with the SIC regarding residents' pill counts revealed she was unaware the residents may not have received medications correctly. The SIC revealed she had received new drug prescriptions for Resident #1 and Resident #6.<br><br>The SIC was not aware if the residents had additional pills. | C 330 | | |

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| C 330 | Continued From page 52<br><br>Interview on 10/7/09 at 10:30 a.m. with the Administrator revealed she was unaware the residents may not have received their medications correctly due to pill counts. She stated residents may have more than one bottle of the same prescription. The Administrator revealed the SIC was working on getting the October 2009 MARS completed.<br><br>THE DATE OF CORRECTION SHALL NOT EXCEED OCTOBER 30,2009. | C 330 | | |
| C 375 | 10A NCAC 13G .1009(a)(1) Pharmaceutical Care<br><br>10A NCAC 13G .1009 Pharmaceutical Care<br>(a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following:<br>(1) an on-site medication review for each resident which includes at least the following:<br>(A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are | C 375 | | |

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| C 375 | Continued From page 53<br>identified and reported to the appropriate prescribing practitioner; and,<br>(B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and,<br>(C) documenting the results of the medication review in the resident's record;<br><br>This Rule is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to obtain review of each resident's drug regimen by a licensed pharmacist, prescribing practitioner, or registered nurse (RN) for the provision of pharmaceutical care at least quarterly for 6 of 6 resident living in the facility. The findings are:<br><br>1. Record review of Resident #1's FL-2 dated 2/9/9 revealed diagnoses of psychotic disorder, alcohol and substance abuse, and status post cerebral vascular accident.<br><br>Review of Resident #1's Resident Register revealed an admission date of 2/1/07.<br><br>Record review of Resident #1's last provision of pharmaceutical care revealed a medication review dated 3/30/09 by a RN.<br><br>Refer to the interview with the Administrator on 10/7/09 at 11:45 a.m. .<br><br>2. Record review of Resident #2's FL-2 dated 7/21/08 revealed diagnoses of schizophrenia paranoid type, gastroesophageal reflux disease, hypertension (HTN), increased cholesterol and liver function tests, HIV, history of syphilis, and status post myocardial infarction. | C 375 | | |

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| C 375 | Continued From page 54<br><br>Review of Resident #2's Resident Register dated 08/25/06 revealed an admission date of 8/17/06.<br><br>Record review of Resident #2's last provision of pharmaceutical care revealed a medication review dated 3/30/09 by a RN.<br><br>Refer to the interview with the Administrator on 10/7/09 at 11:45 a.m. .<br><br>3. Record review of Resident #3's FL-2 dated 3/30/09 revealed diagnoses of paranoid schizophrenia, motor vehicle accident, and hyperlipidemia.<br><br>Review of Resident #3's Resident Register revealed an admission date of 5/18/04.<br><br>Record review of Resident #3's last provision of pharmaceutical care revealed a medication review dated 3/30/09 by a RN.<br><br>Refer to the interview with the Administrator on 10/7/09 at 11:45 a.m. .<br><br>4. Record review of Resident #4's FL-2 dated 5/11/09 revealed diagnoses of schizophrenia chronic paranoid, personality disorder, chronic left hip pain, history of seizure disorder, benign prostate hypertrophy, and hyperlipidemia.<br><br>Review of Resident #4's Resident Register dated 3/30/09 revealed an admission date of 5/7/09.<br><br>Record review of Resident #4's last provision of pharmaceutical care revealed a medication review dated 3/30/09 by a RN.<br><br>Refer to the interview with the Administrator on 10/7/09 at 11:45 a.m. . | C 375 | | |

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| C 375 | Continued From page 55<br><br>5. Record review of Resident #5's FL-2 dated 1/22/09 revealed diagnoses of mild mental retardation, hard of hearing, legally blind, and depression.<br><br>Review of Resident #5's Resident Register dated 2/22/06 revealed an admission date of 2/22/06.<br><br>Record review of Resident #5's last provision of pharmaceutical care revealed a medication review dated 3/30/09 by a RN.<br><br>Refer to the interview with the Administrator on 10/7/09 at 11:45 a.m. .<br><br>6. Record review of Resident #6's FL-2 dated 01/22/09 revealed diagnoses of bipolar disorder, depression, and resolved dependency traits.<br><br>Review of Resident #6's Resident Register dated 05/7/06 revealed an admission date of 08/17/05.<br><br>Review of Resident #6's last provision of pharmaceutical care revealed a medication review dated 3/30/09 by a RN.<br><br>Interview on 10/7/09 at 11:45 a.m. with the Administrator revealed the facility had not contacted the registered nurse for a quarterly medication review after 3/30/09. | C 375 | | |
| C 502 | G.S. 131D-4.4(b)(c) Prohibit Smoking in LTC Facilities<br><br>G.S. 131D-4.4 Adult care home minimum safety requirements; smoking prohibited inside long-term care facilities; penalty.<br>(b) Smoking is prohibited inside long-term care facilities. As used in this section: | C 502 | | |

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| C 502 | Continued From page 56<br><br>(1) 'Long-term care facilities' include adult care homes, nursing homes, skilled nursing facilities, facilities licensed under Chapter 122C of the General Statutes, and other licensed facilities that provide long-term care services.<br>(2) 'Smoking' means the use or possession of any lighted cigar, cigarette, pipe, or other lighted smoking product.<br>(3) 'Inside' means a fully enclosed area.<br>(c) The person who owns, manages, operates, or otherwise controls a long-term care facility where smoking is prohibited under this section shall:<br>(1) Conspicuously post signs clearly stating that smoking is prohibited inside the facility. The signs may include the international 'No Smoking' symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.<br>(2) Direct any person who is smoking inside the facility to extinguish the lighted smoking product.<br>(3) Provide written notice to individuals upon admittance that smoking is prohibited inside the facility and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.<br><br>This Rule is not met as evidenced by:<br>THIS IS A TYPE B VIOLATION WITH A DIRECTED DATE OF CORRECTION.<br><br>Based on observation, interview and record review, the facility failed to assure smoking was prohibited inside the facility by 1of 2 staff (Staff A). The findings are:<br><br>During the initial facility tour conducted on 10/6/9 at 8:30 a.m., two "No Smoking" signs were observed posted in the facility. One sign was posted on the male residents ' bedroom door | C 502 | | |

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| C 502 | Continued From page 57<br>adjacent to the living room. The other sign was posted on the door in hallway leading to the other resident bedrooms. Staff A's bedrooms was also on this hallway.<br><br>Based on observation on 10/6/09 at 9: 15 a.m. there was a beeping sound coming from the smoke alarms. Subsequent interview with staff from Emergency Management Services and DHSR Construction Section revealed the sound from the smoke alarms indicated the batteries needed to be changed.<br><br>Interview with a construction section staff on 10/8/09 at 9:40 a.m. revealed he smelled smoke in Staff A's bedroom when entering the room. The construction section staff reported observation of several cigarettes butts in ash trays in Staff A's bedroom.<br><br>Interview with the Staff A on 10/8/09 at 9:40 a.m. revealed, "I took two puffs of a cigarette and put it out". Staff A stated that she knew there was "no smoking" allowed in the facility.<br><br>Interview with the administrator on 10/8/09 at 10:10 a.m. revealed there is to be "No Smoking" in the facility and there were signs posted on the hallway door toward the bedrooms. The administrator reported that the facility has no smoking policy, because the residents know they are not supposed to smoke in the facility. The administrator was not aware Staff A had been smoking in her bedroom.<br><br>On 10/8/09 at 9:50 a.m. the construction unit staff revealed that there was no operational smoke alarms in Staff A's bedroom and the alarms were hanging from the ceilings in the staff's bedroom and in the one of the resident bedrooms where | C 502 | | |

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| C 502 | Continued From page 58<br>residents resided.<br><br>THE DIRECTED DATE OF CORRECTION SHALL NOT EXCEED OCTOBER 30, 2009. | C 502 | | |
| C 912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and staff and resident interviews, the facility failed to assure every resident had the right to receive care and services which were adequate, appropriate and in compliance with rules and regulations as related to supervision,smoking health care referral and follow-up, qualifications of medication administration staff,health care personnel registry,criminal background, food supply and medication administration. The findings are:<br><br>1. Based on observation, interview and record review the facility failed to assure staff met the minimum safety requirements by assuring that smoking was prohibited inside the facility. [Refer to Tag 502 G.S. 131D- 4.4 (Type B Violation)]<br><br>2. Based on interviews and record review, the facility failed to assure that 1 of 1 staff (Staff A) who administered medications had successfully passed the written exam within 90 days of successful completion of the clinical skills validation portion of the competency evaluation. | C 912 | | |

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| C 912 | Continued From page 59<br><br>[Refer to Tag 132 10A NCAC 13 G .0403 (b) Qualifications of Medication Staff (Type B Violation)]<br><br>3. Based on staff interviews and record reviews, the facility failed to assure 1 of 2 staff members (Staff B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry.[Refer to Tag 145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications (Type B Violation)]<br><br>4. Based on interviews and record reviews, the facility failed to assure 1 of 2 employees (Staff B) have a criminal background check before employment. [Refer to Tag 147 10A NCAC 13G .0406(a)(7) Other Staff Qualifications (Type B Violation)]<br><br>5. Based on interview and record review the facility failed to ensure referral and follow-up to meet routine and acute health care needs of 1 of 6 sampled residents who complained of a skin rash, sore buttocks and pain from long finger nails (Resident #3).[Refer to Tag 246 10A NCAC 13G .0902 (b) Health Care (Type B Violation)]<br><br>6. Based on observation and interviews the facility failed to assure a three-day supply of perishable food and a five-day supply of non-perishable food in the facility.[Refer to 259 10A NCAC 13G .0904 (a) (4) Nutrition and Food Service (Type B Violation)]<br><br>7. Based on observation, interview, and record review, the facility failed to assure the medications were administered as ordered by the licensed prescribed practitioner. [Refer to 330 10A NCAC 13G .1004 (a) Medication Administration ( Type B Violation)] | C 912 | | |

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| C 912 | Continued From page 60<br><br>8. Based on observation and staff interview, the facility failed to maintain the building and electrical equipment, such as the facility's smoke alarms and clothes dryer, in a safe and operating condition. [Refer to Tag 102 10A NCAC 13G .0317 (a) Building Service Equipment] | C 912 | | |
| C 914 | G.S 131D-21(4) Declaration Of Resident's Rights<br><br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observation, and interview, the facility failed to assure every resident was free of neglect. The findings are:<br><br>1. Confidential interview revealed shortly after their admission to the facility, residents were instructed by staff on the housekeeping duties they must do. Residents were assigned to mop the facility floors early each morning. It was indicated the floors are mopped daily early in the morning.<br><br>Confidential interview revealed residents have been assigned to mop floors, wash and dry dishes, collect and help bag up trash to place in facility's vehicles, and sweep floors. It also indicated several residents load Resident #3's wheelchair in and out of the facility's vehicles.<br><br>Confidential interview revealed resident's are assigned to clean under the bathroom cabinets. Continued interview revealed resident's are assigned to wash dishes,clean the stove, empty trash can and sweep the floors. | C 914 | | |

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| C 914 | Continued From page 61<br><br>Confidential interview revealed residents do not want to do the chores that were assigned to them, however, if the chores are not done the facility would not be cleaned and the residents do not want to stay in a dirty place.<br><br>Confidential interview revealed residents have to hang their clothes up through out the home as well as other residents; because, the clothes dryer does not work. It was stated that residents have to purchase their own laundry detergent. It was also revealed that resident have to do their laundry and one resident has to wash another resident's clothes.<br><br>Interview with the Administrator on 10/8/09 at 10:30 a.m. revealed resident's make up their beds. It was indicated that the residents are physical able to do things for themselves and they are expected to do for themselves and to keep there personal areas cleaned. "This is their house they should want it cleaned".<br><br>2. Based on observation,and interview the administrator failed to assure that all required duties were carried out in the home. [Refer to Tag 185 10A NCAC 13G .0601 (a) Management and Other Staff ( Type A Violation)]<br><br>3. Based on observation and interview, the administrator failed to assure that 4 of 6 sampled residents (#2, #3, #4, and #5) were not left alone in the home without a staff member. [Refer to Tag 186 10A NCAC 13G .0601(b) Management and other Staff (Type A Violation)].<br><br>4. Based on observations, interviews and record review, the facility failed to provide supervision for 4 of 4 residents (#2, #3, #4 and #6) who were left unsupervised, waiting for transportation back to | C 914 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL092016 | A. BUILDING _____ B. WING _____ | 10/08/2009 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JONES FAMILY CARE HOME | 3620 BARWELL ROAD RALEIGH, NC 27610 |

| (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 914 | Continued From page 62<br><br>the facility, outside of a local community building on three known occasions (7/30/09, 8/5/09 and 10/6/09)[Refer to Tag 243 10A NCAC 13G .0901 (b) Personal Care and Supervision (Type A Violation)] | C 914 | | |