

| Division of Health Service Regulation                         |                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____ |  | (X3) DATE SURVEY COMPLETED<br><br>04/24/2019 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                    | FCL017052                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
| (X4) ID PREFIX TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                             | ID PREFIX TAG                                                                        | PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X5) COMPLETE DATE                                                |  |                                              |
| C 000                                                         | Initial Comments                                                                                                                                                                                                                                                                                                                                   | C 000                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
|                                                               | The Adult Care Licensure Section and Caswell County Department of Social Services conducted an annual survey on April 24, 2019.                                                                                                                                                                                                                    |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
| C 246                                                         | 10A NCAC 13G .0902(b) Health Care                                                                                                                                                                                                                                                                                                                  | C 246                                                                                | Effective date April 25 <sup>th</sup> 2019 SIC will continue to review all referral request after all primary care visits from primary physician which are performed on the 15 <sup>th</sup> of each month. SIC to schedule all referrals and report to the Administrator if their becomes an with attending the appointment. SIC to ensure per facility policy that if an resident doesn't want to attend an appointment that an refusal of care form is signed by the resident.                                                                                                                                                                                                                                                                                                                                                                                                                               | 04/25/2019                                                        |  |                                              |
|                                                               | 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.                                                                                                                                                                                               |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
|                                                               | This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure 1 of 3 sampled residents (Resident #1) received healthcare referral and follow-up services for a diabetic resident who needed to see a podiatrist and an eye doctor as requested by the primary care provider (PCP). |                                                                                      | SIC reviewed referral for (resident #1) and made appointment with optometrist/podiatrist for (resident #1) who communicated to the staff that she did not want to go to the "eye doctor or to the foot doctor" Resident #1 communicated to the staff that she would let the staff know when she wanted to go to the "eye doctor and foot doctor"! Administrator was informed of the refusal but when Resident #1 was asked to sign a facility "REFUSAL OF CARE" form Resident #1 refused to sign! Administrator through weeks of negotiations finally convinced resident #1 to go to the podiatrist to get toenails cut on May 20, 2019. Resident #1 is still refusing to go to the optometrist. However, the facility is now contracting with Dr. Michael Vollmer, OD PLLC 1500 Meadowview Dr. Wilkesboro, NC 28697 who will coming to the facility to perform mobile comprehensive eye services on 06/27/2019 | 06/27/2019                                                        |  |                                              |
|                                                               | The findings are:                                                                                                                                                                                                                                                                                                                                  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
|                                                               | Review of Resident #1's current FL-2 dated 01/16/19 revealed diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease.                                                                                                  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
|                                                               | Review of a PCP visit summary for Resident #1 dated 01/16/19 revealed Resident #1 needed a diabetic foot exam and eye exam.                                                                                                                                                                                                                        |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |
|                                                               | Review of Resident #1's Licensed Health Professional Support evaluation dated 02/04/19 revealed:<br>-There was documentation Resident #1's toenails were very long and need to be trimmed as soon                                                                                                                                                  |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                   |  |                                              |

(X5) DATE

If continuation sheet 1 of 23

POC has been reviewed and accepted 06/06/19.

Kathy Gray

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                                                                                          |                                                 |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                                        | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                          |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>(DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |
| C246                                                          | <p>Continued From page 1</p> <p>as possible.</p> <p>-There was documentation the PCP had requested on 01/16/19 for Resident #1 to have foot care with a podiatrist.</p> <p>-There was documentation Resident #1 was unsure of her last eye exam.</p> <p>There was documentation the PCP had requested on 01/16/19 for Resident #1 to have an eye exam scheduled.</p> <p>-There was a second notation to "please make sure these appointments were made."</p> <p>Interview with Resident #1 on 04/24/19 at 1:06 pm revealed:</p> <p>-She had not been to the eye doctor in several years; she thought she needed to go to the eye doctor for a check-up.</p> <p>-She had not been to the podiatrist since she had moved to the facility.</p> <p>-She had asked several different named staff about going to the podiatrist but no one had made her an appointment.</p> <p>-She needed to go to the podiatrist because her toenails were bothering her</p> <p>Observation of Resident #Ts toenails on 04/24/19 at 1:06 pm revealed her toenails extended the length of her toes.</p> <p>Interview with the Medication Aide (MA) on 04/24/19 at 1:17 pm revealed:</p> <p>-She usually worked at night; she worked days on the weekend.</p> <p>-She did not know Resident #1's PCP had recommended an appointment for the eye doctor and podiatrist.</p> <p>-The daytime MA was responsible for following up on appointments.</p> <p>-Resident #1 had not asked her about a podiatry appointment or complained about her toenails.</p> | C246                                                                                 |                                                                                                                          |                                                 |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                      |                                                                                                                         |                                                 |
|---------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                         |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |
| C246                                                          | <p>Continued From page 2</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/24/19 at 1:31pm revealed:</p> <ul style="list-style-type: none"> <li>-The day shift MA was responsible for making appointments and would then contact her to schedule transportation.</li> <li>-Sometimes the MA would contact her and ask her to make the appointment.</li> <li>-She had not scheduled transportation for or made an appointment for Resident #1 for a podiatrist or eye doctor.</li> <li>-She expected the dayshift MA to make an appointment for Resident #1 and was concerned that an appointment had not been made.</li> </ul> <p>Telephone interview with the dayshift MA on 04/24/19 at 1:43pm revealed:</p> <ul style="list-style-type: none"> <li>-The facility staff had made appointments for Resident #1 to see an eye doctor and podiatrist.</li> <li>-She could not remember when the appointments were scheduled.</li> <li>-She thought the appointment had been rescheduled; she did not know the date</li> <li>-She thought the appointments were scheduled for around 04/04/19.</li> <li>-Names of the eye doctor and podiatrist where appointments were made were provided.</li> <li>-She had not made appointments with the named providers.</li> <li>-The PCP made the appointments for Resident #1.</li> </ul> <p>Telephone interview with the PCP on 04/24/19 at 2:41pm revealed:</p> <ul style="list-style-type: none"> <li>-She did not schedule appointments for any of her residents; the facility was responsible for scheduling appointments.</li> <li>-Resident #1 was diabetic and needed to see an eye doctor and a podiatrist.</li> <li>-She wanted Resident #1 to be scheduled to see</li> </ul> | C246                                                                                 |                                                                                                                         |                                                 |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X5)<br>COMPLETE<br>DATE                        |
| C246                                                          | Continued From page 3<br><br>an eye doctor and a podiatrist.<br><br>Telephone interview with the Administrator on<br>04/24/19 at 3:19pm revealed:<br>-If a resident had an appointment the MA should<br>make the appointment and call the main office to<br>coordinate transportation.<br>-If a resident refused to go to an appointment,<br>they would complete a refusal form and file in the<br>resident's record.<br>-If an appointment was rescheduled, it would be<br>documented in the resident's record.<br>-He was concerned Resident Ts PCP had<br>recommended appointments on 01/16/19 that<br>had not been scheduled.                                                                                                                                              | C246                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |
| C249                                                          | 10A NCAC 13G .0902(c)(3)(4) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(c) The facility shall assure documentation of the<br>following in the resident's record:<br>(3) written procedures, treatments or orders from<br>a physician or other licensed health professional;<br>and<br>(4) implementation of procedures, treatments or<br>orders specified in Subparagraph (c)(3) of this<br>Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record<br>reviews, the facility failed to assure blood<br>pressure checks were completed and<br>documented as ordered for 1 of 3 sampled<br>residents (Resident #1) with an order for blood<br>pressure checks on Monday, Wednesday and<br>Friday.<br><br>The findings are: | C249                                                                                 | Effective date April 24, 2019 Administrator<br>will continue to review medication bi-<br>monthly with SIC and staff. Immediately<br>the Administrator will re-educate staff on<br>faxing new orders and FL2's to the<br>pharmacy. FL2's will be compared to the<br>MAR and clarification will be done<br>immediately. Staff will refer to the facility<br>policy and procedure, right medication,<br>dose, time, route and right patient.<br><br>Effective date April 24, 2019 Administrator<br>will schedule continued education on<br>medication errors for current and future<br>staff. Medication chart audits will be<br>completed for all residents bi-weekly by the<br>SIC for 6 weeks, then will continue with<br>medication reviews bi-monthly with the<br>SIC and staff. | 04/24/2019                                      |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                                                                                                                         |                                                 |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                         |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |
| C249                                                          | <p>Continued From page 4</p> <p>Review of resident's #1's current FL-2 dated 01/16/19 revealed:<br/>-Diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease.<br/>-There was no order for blood pressure (BP) checks three times a week on Monday, Wednesday and Friday.</p> <p>Review of Resident #1's February 2019, March 2019 and April medication administration record (MAR) revealed there was no entry or documentation of ordered three times a week BP checks</p> <p>Review of Resident's #1 March 2019 MAR revealed there was no documentation of weekly BP checks.</p> <p>Review of Resident #1's April 2019 MAR revealed there was no documentation of weekly BP checks</p> <p>Review of Resident #1's physician summary dated 03/15/19 revealed:<br/>-Resident #1 was seen by the facility primary care provider (POP).<br/>-Resident #Ts BP was 123/62</p> <p>Telephone interview with a representative from the facility's contracted pharmacy on 0/24/19 at 11:32 am revealed:<br/>-The FL-2 dated 01/16/19 had not been sent to the pharmacy.<br/>-If the FL-2 had been sent to the pharmacy the order for BP checks on Monday, Wednesday and Friday would have been added to the MAR.</p> | C249                                                                                 |                                                                                                                         |                                                 |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                                                                                          |                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING: _____                                                    | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                          |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>(DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |
| C249                                                          | <p>Continued From page 5</p> <p>Telephone interview with the medication aide (MA) on 04/24/19 at 5:22pm revealed:</p> <ul style="list-style-type: none"> <li>-She did not do BP checks three times a week for Resident #1; it was checked monthly.</li> <li>-She did not see the order for BP checks for Monday, Wednesday and Friday on the FL-2 dated 01/16/19.</li> <li>-She had not checked Resident #1's BP for April 2019.</li> <li>-She did not document the BP on the MAR if it was not an order; the BP's were documented on a separate document.</li> <li>-She did not send Resident #1's FL-2 dated 01/16/19 to the pharmacy; the pharmacy would have put the order on the MAR.</li> <li>-She did not know why she did not send the FL-2 to the pharmacy.</li> </ul> <p>Interview with the Supervisor-in-Charge (SIC) on 04/24/19 at 5:47pm revealed:</p> <ul style="list-style-type: none"> <li>-The day shift MA was responsible for sending the FL-2 to the pharmacy.</li> <li>-She expected the MA to be knowledgeable about the information on the FL-2.</li> <li>-She did not know the FL-2 had not been sent to the pharmacy with orders for BP checks on Monday, Wednesday and Friday.</li> <li>-She expected all orders to be followed.</li> </ul> <p>Interview with Resident #1 on 04/24/19 at 5:28 pm revealed:</p> <ul style="list-style-type: none"> <li>-She had a history of high BP.</li> <li>-She took medication daily for high BP.</li> <li>-No one had taken her BP in a long time.</li> <li>-She did not know how often she was supposed to have her BP checked.</li> </ul> <p>Interview with the Administrator on 04/24/19 at 3:19pm revealed:</p> | C249                                                                                 |                                                                                                                          |                                                 |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X5)<br>COMPLETE<br>DATE                        |
| C249                                                          | Continued From page 6<br><br>-The MA was responsible for making sure the PCP orders were followed.<br>-He expected all orders to be followed.<br>-He was concerned Resident #1's BP was not taken as ordered<br><br>Attempted second telephone interview with Resident #1's PCP on 04/24/19 at 5:23pm was unsuccessful.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | C249                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 |
| C273                                                          | 10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes:<br>(3) Daily menus for regular diets shall include the following:<br>(A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served to the residents twice daily.<br><br>The findings are:<br><br>Observation of the refrigerator on 04/24/19 at 8:55am revealed:<br>-There was one opened gallon of milk in the refrigerator that had one-fourth of milk left in the container.<br>-There was an unopened gallon of milk. | C273                                                                                 | Effective date April 24, 2019 SIC will monitor staff daily to ensure that the menu is being followed and that milk is offered at least twice a day. Two servings of fruit (one serving equals 6 ounces of juice, ½ cup raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. SIC to monitor meal servings for 6 weeks then continue with meal reviews bi-monthly with SIC and staff. | 04/24/2019                                      |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                                                                                         |                                                 |
|---------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                         |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |
| C273                                                          | <p>Continued From page 7</p> <p>-There were no other dairy substitutes.</p> <p>Observation of the lunch meal service on 04/24/19 at 12:00pm revealed the residents were provided with water and tea; milk was not offered.</p> <p>Interview with a resident on 04/24/19 at 12:49pm revealed.</p> <p>-She had not been offered milk in over a week.</p> <p>-She liked milk and would drink milk if it was served or offered.</p> <p>-She had not asked for milk.</p> <p>Interview with a second resident on 04/24/19 at 12:51pm revealed:</p> <p>-She was not offered milk every day; she could not recall the last time she had milk to drink.</p> <p>-She had not asked for milk.</p> <p>-She would drink milk every day; "it is good for your bones."</p> <p>Interview with a third resident on 04/24/19 at 12:53pm revealed:</p> <p>-Staff had given the residents milk to drink three weeks ago but they had not had milk since then.</p> <p>-When they were given milk it was "just a little cup."</p> <p>-She liked milk and would drink it every day if milk was offered.</p> <p>-She had not asked for milk to drink.</p> <p>Interview with a fourth resident on 04/24/19 at 12:59pm revealed:</p> <p>-It had been "ages ago" since they were offered milk to drink in a cup.</p> <p>-She would drink milk every day if it was offered.</p> <p>Interview with a fifth resident on 04/24/19 at 1:06 pm revealed:</p> <p>-She seldom had milk to drink.</p> | C273                                                                                 |                                                                                                                         |                                                 |

Division of Health Service Regulation

|                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |
|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X5)<br>COMPLETE<br>DATE                        |
| C273                                                          | Continued From page 8<br><br>-The staff did not offer milk to drink<br>-She liked milk and would drink it every day.<br><br>Review of the Diet Menu provided by the facility<br>staff revealed the residents were to receive 8<br>ounces of milk with breakfast and dinner meal<br>service; milk and ½ sandwiches were listed as the<br>evening snack on multiple days reviewed.<br><br>Interview with a medication aide (MA) on<br>04/24/19 at 1:17 pm revealed:<br>-She did not offer milk to the residents to drink<br>unless they asked for it.<br>- She had not thought to ask the residents if they<br>wanted milk to drink.<br><br>Interview with the Supervisor in Charge (SIC) on<br>04/24/19 at 2:22 pm revealed:<br>-She expected the MA's to provide milk at the<br>breakfast meal service and to offer milk at the<br>lunch and dinner meal services.<br>-Milk was also offered at snacks.<br>-She had not had any residents complain to her<br>about milk not being offered.<br><br>Telephone interview with the Administrator on<br>04/24/19 at 3:19 pm revealed he was not sure<br>how often milk was on the menu; he expected<br>staff to follow the menu. | C273                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                 |
| C274                                                          | 10A NCA 13G.09014(d)(3)(B) Nutrition and<br>Food Service<br><br>10A NCA 13G.09014(d)(3)(B) Nutrition and<br>Food Service<br>(d)Food requirements in Family Care Homes:<br>(3)Daily menus for regular diets shall include the<br>following:<br>(B)Fruit: Two servings of fruit (one serving<br>equals 6 ounces of juice, ½ cup raw, canned or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | C274                                                                                 | Effective date April 24, 2019 SIC will<br>monitor staff daily to ensure that the<br>menu is being followed and that milk is<br>offered at least twice a day. Two<br>servings of fruit (one serving equals 6<br>ounces of juice, ½ cup raw, canned or<br>cooked fruit; 1 medium-size whole<br>fruit; or ¼ cup dried fruit). One serving<br>shall be a citrus fruit or a single<br>strength juice in which there is 100% of<br>the recommended dietary allowance of<br>vitamin C in each six ounces of juice.<br>The second fruit serving shall be of<br>another variety of fresh, dried or<br>canned fruit. SIC to monitor meal<br>servings for 6 weeks then continue with | 04/24/2019                                      |

|  |  |  |                                             |  |
|--|--|--|---------------------------------------------|--|
|  |  |  | meal reviews bi-monthly with SIC and staff. |  |
|--|--|--|---------------------------------------------|--|

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 9 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                                      |                                                                                                                              |                                                                                              |                                                                                                                         |                                                        |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL017052</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                                       | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HUMPHREY FAMILY CARE HOME</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6245 BURTON CHAPEL ROAD<br/>MEBANE, NC 27302</b> |                                                                                                                         |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |      |  |  |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|
| C274 | <p>Continued From page 9</p> <p>cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations and interviews, the facility failed to assure fruit was served twice daily to residents including a serving of citrus juice or fruit.</p> <p>The findings are:</p> <p>Observation of the food supply on 04/24/19 at 8:55 am revealed:<br/>-There was no canned, fresh, or frozen fruit in the facility.<br/>-There was no container of 100% citrus fruit juice in the facility.</p> <p>Interview with a resident on 04/24/19 at 12:49 pm revealed:<br/>-It had been a long time since she had fruit to eat; they had tangerines at Christmas.<br/>-They had orange juice to drink a couple of weeks ago.</p> <p>Interview with a second resident on 04/24/19 at 12:51 pm revealed:<br/>-It had been a long time since they had fruit to eat.<br/>-They always had canned fruit, never fresh fruit to eat.<br/>-It had been a long time since she had juice to drink</p> <p>Interview with a third resident on 04/24/19 at</p> | C274 |  |  |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 10 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                                      |                                                                                                                              |                                                                                              |                                                                                                                         |  |                                                     |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>FCL017052</b>                   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                                       |  | (X3) DATE SURVEY COMPLETED<br><br><b>04/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HUMPHREY FAMILY CARE HOME</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6245 BURTON CHAPEL ROAD<br/>MEBANE, NC 27302</b> |                                                                                                                         |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |      |  |  |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|
| C274 | <p>Continued From page 10</p> <p>12:53pm revealed:</p> <ul style="list-style-type: none"> <li>-The medication aide (MA) had brought a banana in "a while back" and fixed them a banana sandwich.</li> <li>-It had been a couple of months since she had any other type of fruit.</li> <li>-They rarely had juice to drink</li> </ul> <p>Interview with a fourth resident on 04/24/19 at 12:59 pm revealed:</p> <ul style="list-style-type: none"> <li>-They get canned fruit to eat at times.</li> <li>-The MA had fixed her a banana sandwich about three weeks ago.</li> <li>-She liked fruit and wished it was provided more often.</li> <li>-They had juice sometimes, maybe 2-3 weeks ago.</li> <li>-She loved orange juice and would drink it every day.</li> </ul> <p>Interview with a fifth resident on 04/24/19 at 1:06 pm revealed:</p> <ul style="list-style-type: none"> <li>-She could not recall the last time she had fruit to eat, it had been a long time.</li> <li>-They seldom had juice to drink, but she would drink it every day.</li> </ul> <p>Review of the Diet Menu provided by the staff for 04/24/19 revealed the residents were to receive orange juice with the breakfast meal service and ½ fresh orange at the dinner meal service.</p> <p>Observation of the lunch meal service on 04/24/19 at 12:00 pm revealed peaches were provided to the residents with their lunch.</p> <p>Interview with the MA on 04/24/19 at 1:17 pm revealed:</p> <ul style="list-style-type: none"> <li>-The Supervisor in Charge (SIC) brought two cans of peaches in for the lunch meal service.</li> </ul> | C274 |  |  |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 11 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                              |                                                                        |                                                                                      |                                                                                                                         |                                                 |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                    |                                                                                                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                         |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |                                                                        | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |      |  |  |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|
| C274 | Continued From page 11<br><br>She served mandarin oranges last week.<br>-The SIC bought fruit cocktail and peaches.<br>-The MAs brought fruit to the residents.<br>-The residents had juice to drink last week.<br><br>Interview with the SIC on 04/24/19 at 2:22pm revealed:<br>-She bought the groceries for the facility.<br>-Last week she bought apples, bananas, and canned fruit.<br>-Last week she bought 10 cans of 100% juice; each can of juice would serve a meal.<br>-No one had told her they did not have fruit or juice available to serve.<br><br>Telephone interview with the Administrator on 04/24/29 at 3:19pm revealed:<br>-Fruit should be provided daily.<br>-The requirements were listed on the menu, and he expected the staff to follow the menu and provide and document appropriate substitutions. | C274 |  |  |
| C330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<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>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled                                                                                                                                                                         | C330 |  |  |

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 12 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                        |                                                                                      |                                                                                                                 |                                              |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>FCL017052                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                               | (X3) DATE SURVEY COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                 |                                              |
| (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                           |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |      |  |  |
|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|
| C330 | <p>Continued From page 12</p> <p>residents (#1) related to a bronchodilator.</p> <p>The findings are:</p> <p>Review of Residents #1 current FL-2 dated 01/16/19 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease.</li> <li>-There was no order for Spriva handihaler, inhale contents of one capful daily. (Spriva is used to prevent bronchospasm caused by COPD and reduce flare-ups of serious symptoms.)</li> </ul> <p>Review of the Primary Care Provider's (PCP) visit note dated 03/15/19 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had a decreased Forced vital capacity (FVC) indicating severe restriction (FVC is the largest amount of air that you can forcefully exhale after breathing in as deeply as you can. A lower than normal FVC reading indicates restricted breathing).</li> <li>-Tobacco cessation information was provided</li> </ul> <p>Review of Resident #1's March 2019 MAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Spriva handihaler, inhale one capsule through handihaler daily.</li> <li>-Spriva was documented as administered daily from 03/01/19-03/31/19.</li> </ul> <p>Review of Resident #1's April 2019 MAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Spriva handihaler, inhale one capsule through handihaler daily.</li> <li>-Spriva was documented as administered daily from 04/01/19-04/24/19.</li> </ul> | C330 |  |  |
|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 13 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                                      |                                                                                                                              |                                                                                              |                                                                                                                         |                                                        |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL017052</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                                       | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/24/2019</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HUMPHREY FAMILY CARE HOME</b> |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6245 BURTON CHAPEL ROAD<br/>MEBANE, NC 27302</b> |                                                                                                                         |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 14 of 23

Division of Health Service Regulation

|                                                               |                                                                                |                                                                                      |                                                                       |                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                       |                                                 |
| (X4) ID<br>PREFIX                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL | ID<br>PREFIX                                                                         | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE     | (X5)<br>COMPLETE                                |

| TAG  | REGULATORY OR LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TAG  | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | DATE |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------|------|
| C330 | <p>Continued From page 14</p> <p>-If Resident #1 had been wheezing she would have asked Resident #1 if she wanted to use the Spiriva handihaler.</p> <p>-She did not know the Spiriva handihaler was supposed to be used every day.</p> <p>-She had initialed the MAR for the Spiriva and forgot to circle her initials that she had not administered.</p> <p>-She thought the Spiriva handihaler was as needed, so she had not offered it to Resident #1</p> <p>-She should have read the MAR closer.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/24/19 at 1:31pm revealed:</p> <p>-She expected the MA to use the MAR to administer medications; if a resident did not take a medication the MA should initial, circle and sign the reason why on the back of the MAR.</p> <p>-The MARs were audited every 1-2 months; the MARs were last audited in February 2019.</p> <p>-The SIC compared medications on hand with the MARs when the records were audited.</p> <p>-She expected the medication to be in its original packaging; the Spiriva handihaler should have not been in a plastic bag.</p> <p>-She was concerned the Spiriva handihaler had not been administered as ordered.</p> <p>-Resident #1 could have respiratory problems without her medication.</p> <p>Interview with a second SIC on 04/24/19 at 2:22 pm revealed:</p> <p>-She was concerned the Spiriva handihaler had not been administered as ordered.</p> <p>-There was no way they had administered the Spiriva handihaler if there were still medications on hand and it had not been dispensed since 03/04/19.</p> <p>-The MA should not be signing the MAR if Sprivia handihaler had not been administered.</p> | C330 |                                                 |      |

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 15 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                              |                                                                                      |                                                                                                          |                                              |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>FCL017052                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                        | (X3) DATE SURVEY COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                          |                                              |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE                     |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |     |             |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-------------|
| C330 | Continued From page 15                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 330 | DEFICIENCY) |
|      | <p>Telephone interview with the PCP on 04/24/19 at 2:41pm revealed:</p> <ul style="list-style-type: none"> <li>-She would be concerned if Resident #1's Spiriva handihaler was not being administered as ordered.</li> <li>-Resident #1 was a smoker and had COPD and needed to be administered her bronchodilator.</li> <li>-If Resident #1 was not using her Spiriva handihaler her COPD could be exacerbated.</li> </ul> <p>Interview with the Administrator on 04/24/19 at 3:19pm revealed:</p> <ul style="list-style-type: none"> <li>-The MA was responsible for making sure the PCP orders were followed.</li> <li>-He expected all orders to be followed.</li> <li>-He was concerned the order for Spiriva was not being followed.</li> <li>-He expected medications to be administered as ordered.</li> </ul> <p>The facility failed to assure medications were administered for 1 of 3 sampled residents (#1) as ordered by the physician which resulted in a bronchodilator not being administered for 36 days who had a recent spirometry test with decreased Forced vital capacity (FVC) indicating severe restriction and severe coughing episodes. Without this medication, this resident was at increased risk of exacerbated COPD. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/24/19 for this violation.</p> <p><b>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 8, 2019</b></p> |     |             |

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 16 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                |                                                                                      |                                                                   |                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                   |                                                 |
| (X4) ID<br>PREFIX                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL | ID<br>PREFIX                                                                         | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE | (X5)<br>COMPLETE                                |

| TAG  | REGULATORY OR LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TAG  | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | DATE       |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| C367 | <p>Continued From page 16</p> <p>10A NCAC 13G .1008(a) Controlled Substances</p> <p>10A NCAC 13G .1008 Controlled Substances<br/>(a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.</p> <p>This Rule is not met as evidenced by:<br/>TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record in order to accurately reconcile controlled substances for 1 of 2 residents sampled (#1) who had orders for a controlled substance used to treat anxiety and agitation. The findings are:</p> <p>Review of Resident #1's current FL-2 dated 01/16/19 revealed:<br/>-Diagnoses included tardive dyskinesia, schizophrenia, depression, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism and history of cerebrovascular disease.<br/>-There was an order for Lorazepam 1mg twice daily as needed for agitation. (Lorazepam is a controlled substance used to treat anxiety and agitation.)</p> <p>Review of Resident #1's April 2019 medication administration record (MAR) revealed:<br/>-There was an entry for Lorazepam 1mg tablet take 1 tablet twice daily as needed for agitation.<br/>-No Lorazepam was documented as</p> | C367 | <p>Effective date April 24, 2019 Administrator will continue to review medication bi-monthly with SIC and staff. Immediately the staff will count controlled medication at the change of each shift, each employee will sign that the medication count is accurate. If the count is not correct the medication aide will immediately contact the SIC. SIC will contract all mediation aides to re-educate on the correct procedure on how to document on the MAR and Controlled Substance Log Sheet.</p> <p>Effective date April 24, 2019 Administrator will schedule continued education on Medication Errors for current and future staff. Medication chart audits will be completed for all residents with controlled substance weekly by the SIC for 6 weeks, and will continue with Medication reviews bi-monthly with SIC and staff.</p> | 04/24/2019 |

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 17 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                        |                                                                                      |                                                                                                                |                                              |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>FCL017052                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                              | (X3) DATE SURVEY COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                |                                              |
| (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                           |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |      |  |  |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|
| C367 | <p>Continued From page 17</p> <p>administered.</p> <p>Review of Resident #1's controlled substance (CS) logs revealed there was no CS log for April 2019 available in the facility.</p> <p>Observation of Resident #1's medications on hand on 04/24/19 at 11:20am revealed:</p> <ul style="list-style-type: none"> <li>-There were four punch cards of Lorazepam 1mg tablets dispensed by an outside pharmacy.</li> <li>-The instructions were to take 1 tablet twice a day as needed for restlessness and agitation.</li> <li>-There was a punch card dispensed on 04/02/19 with 25 tablets; there were 6 tablets remaining in the punch card.</li> <li>-There was a second punch card dispensed on 04/02/19 with 35 tablets; there were 11 tablets remaining in the punch card.</li> <li>-On 04/02/19 there was a total of 60 tablets dispensed; 17 tablets were available to be administered.</li> <li>-There was a third punch card on 04/18/19 with 25 tablets; there were 25 tablets remaining in the punch card.</li> <li>-There was a fourth punch card dispensed on 04/18/19 with 35 tablets; there were 35 tablets remaining in the punch card.</li> <li>-On 04/18/19 there was a total of 60 tablets dispensed; 60 tablets were available for administration.</li> </ul> <p>Telephone interview with a representative from the facility's contracted pharmacy on 04/24/19 at 11:32am revealed:</p> <ul style="list-style-type: none"> <li>-Sixty tablets of Lorazepam 1 mg were dispensed on 04/02/19.</li> <li>-Sixty tablets of Lorazepam 1 mg were dispensed on 04/18/19.</li> <li>-He was not sure why Lorazepam was dispensed on 04/02/19 and again on 4/18/19.</li> </ul> | C367 |  |  |
|------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 18 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                |                                                                                      |                                                                   |  |                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------|--|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____ |  | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                   |  |                                                 |
| (X4) ID                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL | ID<br>PREFIX                                                                         | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE |  | (X5)<br>COMPLETE                                |

| PREFIX TAG | REGULATORY OR LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TAG  | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | DATE |
|------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|-------------------------------------------------|------|
| C367       | <p>Continued From page 18</p> <p>-Medications that were as needed (PRN) would be filled when requested by the facility.</p> <p>Interview with the Medication Aide (MA) on 04/24/19 at 11:44am revealed:</p> <p>-She did not know where Resident #1 's current CS log was located for April 2019.</p> <p>-If she administered Lorazepam to Resident#! she documented on the MAR and the CS log.</p> <p>-She had not administered Lorazepam to Resident #1 in a long time. (She did not recall a date or time frame).</p> <p>-She had only administered Lorazepam to Resident #1 two-three times since she had been admitted.</p> <p>-When the pharmacy brought out the new cycle of medication, they picked up any unused medication from the previous month.</p> <p>Interview with the Supervisor in Charge (SIC) on 04/24/19 at 12:00pm revealed:</p> <p>-She looked in Resident #1's MARs notebook on 04/24/19 at 12:00pm and only saw a blank CS log for Resident #1's Lorazepam.</p> <p>-There was no CS log documenting the medication administered for April 2019.</p> <p>Interview with Resident #1 on 04/24/19 at 1:06pm revealed:</p> <p>-She took Lorazepam "when she felt nervous."</p> <p>-She did not take Lorazepam every day, only when she asked for it.</p> <p>-She had not asked for Lorazepam in several weeks (she could not recall the date).</p> <p>Telephone interview with the MA on 04/24/19 at 1:43pm revealed:</p> <p>-She accidentally took the CS log when she had picked up other papers off the desk.</p> <p>-When she administered Lorazepam to Resident</p> | C367 |                                                 |      |

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 19 of 23  
PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                              |                                                                                      |                                                                                                                         |                                                 |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052                                                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                    |                                                                                                                         | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                         |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                      | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                        |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |      |  |  |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|
| C367 | <p>Continued From page 19</p> <p>#1 she documented it on the CS log.<br/>         -She had also documented administering Resident #1's Lorazepam on the MAR(she did not recall when she had last documented on the MAR for Lorazepam).<br/>         -If the count of the CS log was for 29 Lorazepam remaining, then that was how many she counted when she administered the last dose to Resident #1.</p> <p>Review of a CS log for Lorazepam for Resident #1 provided by the MA on 04/24/19 at 1:58pm revealed:<br/>         -The CS log was dated from the pharmacy for 04/02/19.<br/>         -The CS log corresponded with the 60 tablets dispensed from the pharmacy on 04/02/19.<br/>         -The first entry was dated 04/02/19 with an administration time of 12:00pm with a balance of 59.<br/>         -The last entry was dated 04/24/19 with an administration time of 8:00pm with a balance of 29.<br/>         -There were two MA's signatures on the CS log; the SIC/MA signed administering Lorazepam seven times; the MA signed administering Lorazepam 24 times.<br/>         -On 04/16/19, the SIC/MA's first name was signed and the MA's last name was signed for administering Lorazepam at 8:00am.</p> <p>Based on the review of Resident #1's CS log with an ending balance of 29 tablets available for administration, and the actual 17 Lorazepam tablets available for administration, there were 12 Lorazepam 1mg tablets unaccounted for.</p> <p>Interview with the SIC on 04/24/19 at 2:10pm Revealed:<br/>         -When Lorazepam was administered, it should</p> | C367 |  |  |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 20 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                        |                                                                                      |                                                                                                                 |  |                                              |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>FCL017052                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                               |  | (X3) DATE SURVEY COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                 |  |                                              |
| (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                           |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |      |  |  |
|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|
| C367 | <p>Continued From page 20</p> <p>have been documented on the MAR and the CS log.</p> <p>-She was concerned the CS log provided by the MA did not match the count on hand for Lorazepam.</p> <p>-There was a chance the Lorazepam had been administered and not documented.</p> <p>-She expected the MAs to document on the MAR and on the CS log when Lorazepam was administered.</p> <p>Interview with a second SIC on 04/24/19 at 2:22pm revealed:</p> <p>-There were two SICs for the facility.</p> <p>-She had worked as a MA and administered medication to Resident #1.</p> <p>-She had administered Lorazepam to Resident #1, "but it was probably months ago."</p> <p>-If she administered Lorazepam to Resident #1 she documented on the MAR and on the CS log.</p> <p>-If her initials were not on the MAR, she did not administer Lorazepam to Resident#1</p> <p>-The SIC did not acknowledge if it was her signature on the CS log provided.</p> <p>-MAR audits had been completed in February 2019 for Resident#1</p> <p>-MAR audits were scheduled to be completed every 2-3 months.</p> <p>Telephone interview with the Administrator on 04/24/19 at 3:19pm revealed:</p> <p>-He had helped with the MAR audits in February.</p> <p>-He expected the MARs to be complete and match the medication on hand.</p> <p>-He expected staff to document when they administered Lorazepam to Resident #1.</p> <p>-He was concerned the CS log did not match the medication on hand for Resident #1's Lorazepam.</p> <p>The facility failed to provide readily retrievable</p> | C367 |  |  |
|------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|--|

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 21 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                              |                                                                                      |                                                                                                          |  |                                                 |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL017052               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                        |  | (X3) DATE SURVEY<br>COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                          |  |                                                 |
| (X4) ID<br>PREFIX                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                                  | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE |  | (X5)<br>COMPLETE<br>DATE                        |

| TAG  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | DEFICIENCY |  |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--|
| C367 | Continued From page 21<br><br>records of controlled substances for 1 of 2 residents (#1) and to maintain and accurately document the administration of controlled substances. There were 12 doses of Lorazepam Img unaccounted for and there was a discrepancy in the control log for who had actually administered the medication. This failure could result in the diversion of controlled substances and exploitation of residents' resources, which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/24/19 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 8, 2019 | C367       |  |
| C912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21(2) Declaration of Residents' Rights 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 observations, record reviews, and interviews, the facility failed to assure the residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to controlled substances and medication administration.                                                                                  | C912       |  |

Division of Health Service Regulation  
STATE FORM

FMOL11

If continuation sheet 22 of 23

PRINTED: 05/07/2019  
FORM APPROVED

Division of Health Service Regulation

|                                                               |                                                                                                                        |                                                                                      |                                                                                                                |                                              |
|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              |                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>FCL017052                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING: _____                                              | (X3) DATE SURVEY COMPLETED<br><br>04/24/2019 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUMPHREY FAMILY CARE HOME |                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6245 BURTON CHAPEL ROAD<br>MEBANE, NC 27302 |                                                                                                                |                                              |
| (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                           |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| C912 | <p>Continued From page 22</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. Based on observations, interviews, and record reviews, the facility failed to assure a readily retrievable record in order to accurately reconcile controlled substances for 1 of 2 residents (#1) sampled who had orders for a controlled substance used to treat anxiety and agitation. [Refer to Tag 367, 10A NCAC 13G .1008 Controlled Substances (a) (Type B Violation)].</li> <li>2. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) related to a bronchodilator. [Refer to Tag 330, 10A NCAC 13F 1004(a) Medication Administration (Type B Violation)].</li> </ol> | C912 | <p>Effective date April 24, 2019 Administrator will continue to review medication bi-monthly with SIC and staff. Immediately the staff will count controlled medication at the change of each shift, each employee will sign that the medication count is accurate. If the count is not correct the medication aide will immediately contact the SIC. SIC will contract all mediation aides to re-educate on the correct procedure on how to document on the MAR and Controlled Substance Log Sheet.</p> <p>Effective date April 24, 2019 Administrator will schedule continued education on Medication Errors for current and future staff. Medication chart audits will be completed for all residents with controlled substance weekly by the SIC for 6 weeks, and will continue with Medication reviews bi-monthly with SIC and staff.</p> | 04/24/2019 |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|