

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD 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 The Adult Care Licensure Section and the Caswell County Department of Social Services conducted an annual and follow-up survey on 10/07/24.	C 000	HUMPHREY FAMILY CARE makes every effort to operate in substantial compliance with all applicable regulations. HUMPHREY FAMILY CARE is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. It is the facility's policy to ensure that all exit doors accessible to residents who are determined by a physician or otherwise known to be disoriented are equipped with functioning door alarms of sufficient volume that can be heard by staff when activated. Corrective Action for Affected Residents: On 10/07/24, the Administrator immediately contacted a licensed maintenance contractor to repair/replace the malfunctioning door alarm on the right-side exit door. The door alarm was restored to full functionality on 10/08/24, ensuring all exit doors have working alarms that sound at an appropriate volume when opened. Resident #4's care plan was updated on 10/08/24 to reflect their intermittent disorientation status and the need for staff to monitor their whereabouts. Identifying other Residents having the Potential to be Affected: On 10/08/24, the Administrator and Director of Care conducted a review of all current residents' FL-2s, assessments, and care plans to identify any other residents who are intermittently disoriented. Additionally, all exit door alarms were tested to ensure proper functioning and adequate volume. Measures put into place or Systemic Changes: 1. On 10/09/24, the Administrator implemented a new door alarm checking protocol requiring staff to test all exit door alarms at the beginning of each shift and document results in a Door Alarm Check Log. 2. On 10/09/24, the Administrator created a preventive maintenance schedule for monthly inspection and testing of all door alarm systems. 3. On 10/10/24, all staff received in-service training on: o The importance of functioning door alarms o How to properly test door alarms o The procedure for immediately reporting malfunctioning alarms o The protocol for monitoring residents who are intermittently disoriented 4. A new policy was implemented requiring immediate notification of maintenance and the Administrator of any door alarm malfunction. Plan to Monitor Performance: 1. The Supervisor in Charge will audit the Door Alarm Check Log daily for 4 weeks, then weekly for 8 weeks, and monthly thereafter to ensure compliance. 2. The Administrator will conduct physical checks of all door alarms weekly for 4 weeks, then monthly thereafter. 3. The Director of Care will review all new admissions and quarterly assessments to identify residents with intermittent disorientation and ensure appropriate safety measures are in place. 4. Results of all monitoring activities will be reported monthly to the Quality Assurance Committee for review and additional recommendations if needed. The Administrator will be responsible for overall compliance with this plan. Date of completion: 10/10/24.	10/10/2024
C 069	10A NCAC 13G .0312(g) Outside Entrance and Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 exit doors that were accessible to one resident, who was intermittently disoriented (#4) had a working alarm that was of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Observation of the three exit doors, on the front, and two sides of the facility, on 10/07/24 at various times between 8:00am-5:00pm revealed; -The residents went in and out of a door on the right side of the facility throughout the day.	C 069		

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

TITLE

(X6) DATE

STATE FORM

6899

2J7F11

If continuation sheet 1 of 24

Received, reviewed, and acknowledged on 11/18/24.

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C 069	Continued From page 1 -No alarm sounded when this door was opened and closed. -There was an alarm attached to the door. -The alarm did not make an audible sound when the door was opened. -The other two exit doors both had alarms that made an audible sound when the door was opened. Interview with three residents on 10/07/24 between 8:00am-5:00pm revealed: -One resident stated the alarm worked on the door sometimes, but not all the time; "maybe the battery had given out or something." -A second resident stated, that some days the door alarm worked and some days the door alarm did not work. -A third resident stated, she last heard the door alarm about three weeks ago. Review of Resident #4's current FL-2 dated 08/02/24 revealed: -Diagnoses included schizoaffective disorder, narcissistic personality disorder, and schizophrenia. -The resident was intermittently disoriented. Review of Resident #4's Resident Register revealed an admission date of 05/06/16. Review of Resident #4's assessment and care plan dated 07/25/23 revealed: -This care plan was the most recent care plan in the resident's record. -The resident was sometimes forgetful and needed reminders. -The resident was sometimes disoriented. Interview with a Supervisor In Charge (SIC) on 10/07/24 at 9:35am revealed:	C 069		

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C 069	Continued From page 2 -Resident #4's memory was good, but the resident lived in an imaginary world. -There were door alarms on all the doors. -The alarm on the end door (on the right side of the facility) had been de-activated because the alarm would not shut off. -She thought it was deactivated about a week and a half ago. -The Administrator was aware of the door alarm not working correctly. -The door alarm had been fixed several times. Interview with the Administrator on 10/07/24 at 3:56pm revealed: -Door alarms were in place on the doors to alert staff when a resident went outside. -There were no residents who had been identified as a wanderer at the facility. -He did not know if any residents were intermittently disoriented or not without looking at the residents' records. -He was not aware of the alarm on the end door not working. Telephone interview with Resident #4's primary care provider's (PCP) on 10/07/24 at 4:23pm revealed: -She would consider Resident #4 to be intermittently disoriented. -She had not had any reports of Resident #4 wandering away from the facility.	C 069		
C 079	10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (6) have supply of bath soap, clean towels,	C 079		

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C 079	Continued From page 3 washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This rule apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure toilet paper, soap, and clean towels were available for 5 of 5 residents use in the bathroom used by the residents. The findings are: Observation of the hallway bathroom during the initial tour 10/07/24 at 8:23am revealed: -There was no hand soap in the bathroom. -There were no hand towels or paper towels in the bathroom. -There was no toilet paper in the bathroom. -There was a plastic container sitting on the floor beside the toilet. Interview with a resident on 10/07/24 at 8:27am revealed: -There was no hand soap in the bathrooms to use. -She took her own hand soap and towel to the bathroom. Interview with a second resident on 10/07/24 at 1:34pm revealed: -Residents had to ask for toilet paper before going to the bathroom. -She tried to take her own toilet paper to the bathroom but sometimes she forgot. -She had been to the bathroom before and forgot to ask for toilet paper. -Sometimes the bathroom had soap to wash her hands.	C 079	HUMPHREY FAMILY CARE makes every effort to operate in substantial compliance with all applicable regulations. Nothing in this Plan of Correction is an admission otherwise. HUMPHREY FAMILY CARE is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. It is the facility's policy to maintain adequate supplies of bath soap, clean towels, washcloths, sheets, pillowcases, blankets, and additional coverings for resident use always, including ensuring that bathrooms are properly stocked with toilet paper, hand soap, and paper towels. Corrective Action for Affected Residents: On 10/07/24, immediately upon identification of the deficiency, all resident bathrooms were fully stocked with toilet paper, hand soap, and paper towels. All residents were provided with education regarding the availability of bathroom supplies and instructed to notify staff if supplies are running low rather than using alternative methods. Identifying other Residents having the Potential to be Affected: All residents in the facility have the potential to be affected by this deficient practice. On 10/07/24, all bathrooms in the facility were inspected to ensure proper stocking of supplies. A facility-wide assessment was completed to ensure all residents have access to properly supplied bathrooms. Measures put into place or Systemic Changes: 1. Effective 10/08/24, a new bathroom supply checklist was implemented requiring staff to check and stock bathrooms three times per shift. 2. Wall-mounted soap dispensers, toilet paper holders, and paper towel dispensers were installed in all bathrooms by 10/14/24. 3. A designated storage area for bathroom supplies was established near each bathroom for easy access by staff. 4. All staff received in-service training by 10/14/24 regarding: - o Proper bathroom supply maintenance - o Importance of infection control - o new bathroom supply checklist procedures - o Protocol for immediate restocking when supplies are low Plan to Monitor Performance: 1. The Supervisor in Charge will conduct daily bathroom inspections for two weeks, then three times weekly for two weeks, then weekly for one month to ensure compliance. 2. The Administrator will review completed bathroom supply checklists daily for two weeks, then weekly for one month. 3. Random audits of bathrooms will be conducted by the Administrator twice weekly for four weeks, then monthly thereafter. 4. Results of all monitoring will be documented on a quality assurance form. 5. Any identified issues will be corrected immediately, and staff re-educated as needed. The Administrator will report monitoring results to the Quality Assurance Committee monthly for three months or until substantial compliance is achieved and maintained. The Quality Assurance Committee will assess the effectiveness of the plan and make changes as needed. Date of Completion: 10/14/24	10/14/2024

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C 079	Continued From page 4 Observation of a resident on 10/07/24 at 11:10am revealed: -The resident entered the hallway bathroom. -When the resident exited the hallway bathroom she returned to her room. Observation of the hallway bathroom on 10/07/24 at 11:14am revealed: -There was no toilet paper in the bathroom available to be used. -There was no hand soap, or paper towels available to be used. Interview with the resident on 10/07/24 at 11:14am and 4:58pm revealed: -She had "just used the bathroom." -There was no toilet paper in the bathroom. -She used her washcloth to clean herself after using the bathroom. -She washed the washcloth out and hung the washcloth on her closet door. -She reused her washcloth. -She had forgotten to take her washcloth to the bathroom before and had to go to the bathroom door and ask staff for toilet paper. -Toilet paper was kept in the office because some residents used too much toilet paper. Telephone interview with an Environmental Health Specialist with the local health department on 10/07/24 at 12:15pm revealed: -Resident bathrooms should always have toilet paper, hand soap, and paper towels in the bathroom. -Toilet paper would be more sanitary to use over washcloths. -If the facility did not have and use proper supplies it would increase the risk of spreading fecal matter.	C 079		

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C 079	Continued From page 5 Interview with an Administrator on 10/07/24 at 3:32pm revealed there should be toilet paper, soap, and paper towels in the bathroom at all times. Third observation of the hallway bathroom on 10/07/24 at 12:40pm revealed: -There was toilet paper in the bathroom. -There was no soap or hand towels in the bathroom. Interview with the second Administrator on 10/07/24 at 3:44pm revealed: -Bathrooms should be supplied with toilet paper, soap, hand sanitizer, and paper towels. -Residents should not be using a washcloth as a substitute for toilet paper. Second interview with the SIC on 10/07/24 at 4:05pm revealed: -When she saw the bathroom did not have toilet paper, paper towels, or soap today, 10/07/24, she put the items in the bathroom. -She could not say what the other SIC did or did not do but when she saw it, she fixed it. Telephone interview with the facility's contracted primary care provider (PCP) on 10/07/24 at 4:23pm revealed: -Residents should have toilet paper, soap, and something to dry their hands on in the bathroom. Attempted telephone interview with a second SIC on 10/07/24 at 2:33pm was unsuccessful.	C 079		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights	C 311		

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C 311	Continued From page 6 A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to ensure residents were treated with respect, consideration, and dignity related to the residents being required to dispose of soiled toilet paper into a plastic container and had to carry the container to an outside trash can due to the facility toilets becoming stopped up and at times having to plunge toilets after having a bowel movement (BM). The findings are: Interview with a resident on 10/07/24 at 8:27am revealed: -The toilets got stopped up quite often. -She had to push BM down the toilet with a plunger every time she had a BM. -The toilets backed up when the facility washed a lot of clothes. -The residents were not allowed to put the toilet paper they used to clean themselves into the toilet. -She had to plunge the toilet on Friday, 10/04/24. -She did not like having to plunge the toilet every time she had a BM. -She had to take her used toilet paper outside for months. -She was putting her toilet paper in a container beside the toilet, but a [named] Supervisor-in-Charge (SIC) told her to carry the toilet paper to the outside trash can. -Once she cleaned herself, she took the toilet	C 311	HUMPHREY FAMILY CARE makes every effort to operate in substantial compliance with all applicable regulations. Nothing in this Plan of Correction is an admission otherwise. HUMPHREY FAMILY CARE is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. It is the facility's policy to ensure all residents are treated with respect, consideration, dignity, and full recognition of their individuality and right to privacy in accordance with G.S. 131D-21. Corrective Action for Affected Residents: On 10/07/24, the Administrator immediately discontinued the practice of requiring residents to dispose of toilet paper in containers. All bathroom trash containers were removed from beside toilets. The facility contacted a licensed plumber who completed a thorough assessment and repair of the plumbing system on 10/08/24. All residents were immediately informed they should flush toilet paper and were assured they would no longer need to plunge toilets or carry waste to outside containers. Identifying other Residents having the Potential to be Affected: All residents in the facility have the potential to be affected by this practice. The Administrator conducted interviews with all residents on 10/08/24 to ensure no other dignity concerns existed related to bathroom use or other daily activities. Measures put into place or Systemic Changes: 1. On 10/08/24, the Administrator conducted mandatory in-service training for all staff regarding: - o Resident rights and dignity - o Proper bathroom protocols - o Reporting maintenance issues immediately 2. A preventive maintenance schedule was implemented on 10/09/24 for monthly plumbing system inspections 3. New facility protocol established on 10/08/24 requiring: - o Staff to immediately report any plumbing issues to maintenance - o Maintenance issues to be addressed within 24 hours - o Administrator approval for any temporary measures affecting resident care 4. Emergency maintenance contact list created and posted in staff area on 10/08/24 5. Updated facility policy regarding maintenance requests implemented on 10/09/24 Plan to Monitor Performance: 1. The Supervisor-in-Charge will conduct daily bathroom checks and document any plumbing issues in the maintenance log 2. The Administrator will: - o Conduct weekly interviews with 25% of residents regarding bathroom functionality and dignity concerns - o Review maintenance logs weekly to ensure timely completion of repairs - o Conduct monthly audits of facility maintenance records 3. Quality Assurance Committee will review monthly maintenance reports and resident interviews for three months, then quarterly thereafter The Administrator will report monitoring results to the Quality Assurance Committee monthly. The Quality Assurance Committee will monitor until substantial compliance is achieved and maintained for three consecutive months. Date of Compliance: 10/09/24	10/09/2024

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C 311	Continued From page 7 paper outside. -It was "filthy to have to carry the toilet paper up the hall, open the door, and put the toilet paper in the trash can." -She had gone into the bathroom to use the toilet after another resident and the toilet had not been plunged. -She would have to wait until someone plunged the toilet. -She did not know if the Administrator knew the residents were not allowed to put toilet paper in the toilet. Interview with a second resident on 10/07/24 at 8:43am and 5:01pm revealed: -The facility had poor drainage, and the water backed up into the shower. -Residents were told by the SIC to put toilet paper into a plastic container by the toilet and to take the container to an outside trash can. -If she had a BM, the toilet was not going to flush without being plunged. -She recalled having to plunge the toilet last weekend after the storm (09/27/24). -The residents plunged the commodes themselves when they had a BM. -Only one resident was not able to plunge the commode, and she would plunge the commode for that resident. Interview with a third resident on 10/07/24 at 9:00am revealed: -When she urinated, she put the used toilet paper into the container beside the toilet. -Urine flushed fine in the toilet. -When she had a BM, she put the used toilet paper in the container beside the toilet. -She had not had to plunge the toilet "in a while." Interview with a fourth resident on 10/07/24 at	C 311		

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C 311	Continued From page 8 9:08am and 3:02pm revealed: -The staff wanted the residents to put the toilet paper into a container and take the container outside to the trashcan. -Sometimes BMs flushed and sometimes the toilet would need to be plunged. -She had to plunge the toilet last week when it rained a lot. Interview with a fifth resident on 10/07/24 at 1:34pm revealed she thought it was "absurd" that she had to put toilet paper in the plastic container. Interview with the SIC on 10/07/24 at 9:28am revealed: -Used toilet paper was to be put into the container beside the commode and the resident then took the container outside. -One of the [named] residents was not able to take the container outside to be emptied. -The last time she recalled the toilets backing up was about one and a half weeks ago. -Some of the residents who had mental health issues would forget and put toilet paper into the toilet. -Two [named] residents were not able to plunge the toilets on their own. -The Administrator was aware the residents were not putting toilet paper in the toilets because the toilets were backing-up. Telephone interview with an Environmental Health Specialist with the local health department on 10/07/24 at 12:15pm revealed: -Residents in the facility should be able to lead a normal life without having to worry if the toilet was going to back up when they used the bathroom. -He did not think putting used toilet paper into a plastic container was sanitary. -Used toilet paper should be flushed down the	C 311		

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C 311	Continued From page 9 toilet. -Toilet paper would be more sanitary to use over washcloths. -If the facility did not have and use proper supplies it would increase the risk of spreading fecal matter. Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She did not know anything about the residents putting toilet paper into a container in the bathroom. -She knew at one time there were a couple of residents who were putting too much toilet paper into the toilet causing the toilet to back up. -Used toilet paper should be put in the toilet. -The only thing that should be placed in a container in the bathroom was paper towels. -Wash cloths should not be used in the place of toilet paper. -She would not use a washcloth, and she absolutely would not expect a resident to do this. Interview with the second Administrator on 10/07/24 at 3:44pm revealed: -Toilet paper should go into the toilet. -He had not told staff to tell the residents to put toilet paper into a container and not the toilet. -The residents should not be putting used toilet paper into a container. -Residents should not be using a washcloth as a substitute for toilet paper. Telephone interview with the facility's contracted primary care provider (PCP) on 10/07/24 at 4:23pm revealed: -Toilet paper should be flushed in the toilet. -Not flushing toilet paper down the toilet was "just nasty." -Used toilet paper, that kind of waste, should not	C 311			

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C 311	Continued From page 10 be put in a container to be carried outside to a trash can, that would be a public health issue. -Wash cloths were to be used for one-time use and not washed out and hung up to dry. -Residents not being able to flush toilet used paper in the toilet was a resident rights issue, "definitely a dignity issue." Attempted telephone interview with a second SIC on 10/07/24 at 2:33pm was unsuccessful. The facility failed to ensure the residents' rights were maintained by requiring the residents to put used toilet paper into a trash can and carry the trash can outside after each time they used the bathroom and to have to plunge a commode after having BMs. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/07/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2024.	C 311		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior	C 341		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 341	Continued From page 11 to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the recording of the administration of medication on the medication administration record immediately following administration of the medication to the resident for 3 of 3 residents (#1, #2, and #3). The findings are: - Review of Resident #1's current FL-2 dated 07/16/24 revealed: -Diagnoses included hyponatremia, major depression, and mild intellectual disability. -There was an order for Hydroxyzine HCL (an antihistamine) 25mg daily. -There was an order for Melatonin (used to aid in sleep) 3mg, take two tablets at bedtime. -There was an order for Senna (a stool softener) 8.6mg take one tablet at bedtime. -There was an order for Metformin HCL (used to treat diabetes) 1000mg, take one tablet twice daily. -There was an order for Famotidine (used to reduce acid) 20mg twice daily. -There was an order for Aspirin EC (used to reduce the risk of heart attack) 81mg once daily. -There was an order for Loratadine (used to treat allergies) 10mg take one tablet daily. -There was an order for Gabapentin (used to treat nerve pain) 300mg take one tablet three times daily. Review of Resident #1's medication	C 341	HUMPHREY FAMILY CARE makes every effort to operate in substantial compliance with state regulations. Nothing in this Plan of Correction is an admission otherwise. HUMPHREY FAMILY CARE is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. It is the facility's policy that medication administration documentation must occur immediately following the administration of medication to the resident and observation of the resident taking the medication, prior to administering another resident's medication. Pre-charting is prohibited. Corrective Action for Affected Residents: On 10/07/24, the Director of Nursing reviewed all medication administration records for Residents #1, #2, and #3 to ensure all medications were administered as ordered. The medication aide was immediately re-educated on proper documentation procedures. All missing documentation was addressed with a late entry note and medication verification was completed to ensure all medications were administered as ordered. Identifying other Residents having the Potential to be Affected: On 10/07/24, the Director of Nursing conducted an audit of all current residents' medication administration records for the past 7 days to identify any similar documentation issues. Any identified documentation discrepancies were addressed immediately with proper late entry documentation and medication verification. Measures put into place or Systemic Changes: - On 10/08/24, the Director of Nursing provided mandatory in-service education to all medication aides regarding: - o Proper medication administration documentation procedures - o Prohibition of pre-charting - o Requirement to document immediately after each medication administration - o Consequences of medication documentation errors - A new medication administration workflow was implemented on 10/08/24 requiring: - o Documentation after each individual resident's medication administration - o Use of a mobile medication cart with documentation supplies - o Supervisor spot checks during medication passes - Updated medication administration policies and procedures were implemented on 10/08/24 to reflect these changes. Plan to Monitor Performance: - The Director of Nursing or designee will conduct daily medication administration record audits for 2 weeks, then three times weekly for 2 weeks, then weekly for 1 month to ensure compliance with proper documentation procedures. - The Director of Nursing or designee will conduct random medication pass observations three times weekly for 4 weeks, then weekly for 2 months to ensure proper documentation timing. - Results of these audits will be documented on a Medication Administration Compliance Audit Tool. - Any identified issues will be addressed immediately through staff re-education and corrective action. The Administrator will report monitoring plan results to the Quality Assurance Committee monthly for three months or until substantial compliance is achieved and maintained. The Quality Assurance Committee will review the effectiveness of the plan and make changes as needed to ensure continued compliance. Date of Compliance: 10/08/24	10/8/2024	

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C 341	Continued From page 12 administration record (MAR) for October 2024 from 10/06/24-10/07/24 revealed: -There was an entry for Hydroxyzine HCL 25mg once daily with a scheduled administration time of 8:00pm. -Hydroxyzine was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Melatonin 3mg, take 2 tablets once daily with a scheduled administration time of 8:00pm. -Melatonin was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Senna 8.6mg once daily with a scheduled administration time of 8:00pm. -Senna was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Metformin HCL 1000mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Metformin was not documented as administered on 10/06/24 at 8:00pm or on 10/07/24 at 8:00am. -There was an entry for Famotidine 20mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Famotidine was not documented as administered on 10/06/24 at 8:00pm or 10/07/24 at 8:00am. -There was an entry for Aspirin EC 81mg once daily with a scheduled administration time of 8:00am. -Aspirin was not documented as administered on 10/07/24 at 8:00am. -There was an entry for Loratadine 10mg once daily with a scheduled administration time of 8:00am. -Loratadine was not documented as administered on 10/07/24 at 8:00am. -There was an entry for Gabapentin 300mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.	C 341			

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C 341	Continued From page 13 -Gabapentin was not documented as administered on 10/06/24 at 2:00pm and 8:00pm or on 10/07/24 at 8:00am. Interview with Resident #1 on 10/07/24 at 8:43am revealed the medication aide (MA) had administered her medications yesterday, 10/06/24, and today, 10/07/24. Attempted telephone interview with the MA on 10/07/24 at 2:33pm was unsuccessful. Refer to the interview with the MA on 10/07/24 at 8:12am and 8:19am. Refer to the interview with the Administrator on 10/07/24 at 3:32pm. 2. Review of Resident #2's current FL-2 dated 08/02/24 revealed diagnoses of schizophrenia, hypothyroidism, and overactive bladder. -There was an order for Oxybutynin (used to treat an overactive bladder) 5mg daily. -There was an order for Miralax (stool softener) 17g in 8 ounces water daily. -There was an order for Desmopressin acetate (used to treat an overactive bladder) 0.2mg, take two tablets at bedtime. -There was an order for Lamotrigine 150mg (used to treat seizures) 150mg, take one tablet at bedtime. -There was an order for Melatonin (used to aid in sleep) 3mg, take one tablet at bedtime. Review of Resident #2's medication administration record (MAR) for October 2024 from 10/06/24-10/07/24 revealed: -There was an entry for Oxybutynin 5mg once daily with a scheduled administration time of 8:00am.	C 341			

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C 341	Continued From page 14 - Oxybutynin was not documented as administered on 10/07/24 at 8:00am. - There was an entry for Miralax once daily with a scheduled administration time of 8:00am. - Senna was not documented as administered on 10/07/24 at 8:00am. - There was an entry for Desmopressin acetate, take two tablets at bedtime with a scheduled administration time of 8:00pm. - Desmopressin was not documented as administered on 10/06/24 at 8:00pm. - There was an entry for Lamotrigine 150mg once daily with a scheduled administration time of 8:00am and 8:00pm. - Lamotrigine was not documented as administered on 10/06/24 at 8:00pm. - There was an entry for Melatonin 3mg, take 1 tablet once daily with a scheduled administration time of 8:00pm. - Melatonin was not documented as administered on 10/06/24 at 8:00pm. Interview with Resident #2 on 10/07/24 at 9:08am revealed the medication aide (MA) had administered her medications yesterday, 10/06/24 and today, 10/07/24. Attempted telephone interview with the MA on 10/07/24 at 2:33pm was unsuccessful. Refer to the interview with the MA on 10/07/24 at 8:12am and 8:19am. Refer to the interview with the Administrator on 10/07/24 at 3:32pm. 3. Review of Resident #3's current FL-2 dated 07/16/24 revealed: - Diagnoses included Diabetes type 2, chronic obstructive pulmonary disorder, arthritis, and	C 341		

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C 341	Continued From page 15 hypertension. -There was an order for Ziprasidone HCL (used to treat schizophrenia) 40mg twice daily. -There was an order for Cogentin (used to treat tremors) 1mg one tablet twice daily. -There was an order for Prolixin (used to treat schizophrenia) 5mg one tablet twice daily. -There was an order for Gabapentin (used to treat nerve pain) 100mg take two tablets twice daily. Review of Resident #3's medication administration record (MAR) for October 2024 from 10/06/24-10/07/24 revealed: -There was an entry for Ziprasidone HCL 40mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Ziprasidone was not documented as administered on 10/06/24 at 8:00pm or 10/07/24 at 8:00am. -There was an entry for Cogentin 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Cogentin was not documented as administered on 10/06/24 at 8:00pm of 10/07/24 at 8:00am. -There was an entry for Prolixin 5mg once daily with a scheduled administration time of 8:00am and 8:00pm. -Prolixin was not documented as administered on 10/06/24 at 8:00pm of 10/07/24 at 8:00am. -There was an entry for Gabapentin 100mg, take two tablets twice daily with a scheduled administration time of 8:00am and 8:00pm. -Gabapentin was not documented as administered on 10/06/24 at 8:00pm of 10/07/24 at 8:00am. Interview with Resident #3 on 10/07/24 at 9:00am revealed the medication aide (MA) had administered her medications on 10/06/24 and	C 341		

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C 341	Continued From page 16 today, 10/07/24. Attempted telephone interview with the MA on 10/07/24 at 2:33pm was unsuccessful. Refer to the interview with the MA on 10/07/24 at 8:12am and 8:19am. Refer to the interview with the Administrator on 10/07/24 at 3:32pm. Interview with the MA on 10/07/24 at 8:12am revealed: -She called the residents to the kitchen one at a time to administer the residents' medications. -She administered the residents' medications on 10/06/24 and 10/07/24. -She documented on the resident's MAR after she administered the medications. Observation of the MA on 10/07/24 at 8:19am revealed she was documenting her initials on multiple MARs after she had already administered all the residents' medications. Second interview with the MA on 10/07/24 at 8:19am revealed she was documenting on the all the yellow lines on the MAR because that was the medications she administered this morning, 10/07/24. Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She expected the SIC to match the medications on hand to the MAR before administering medication. -Once the medication was administered, the SIC should immediately document the administration on the MAR. -If the SIC was documenting on the MAR as soon	C 341		

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C 341	Continued From page 17 as the medication was administered, there would have been no errors with the documentation.	C 341			
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 2 of 3 sampled residents (#1, #2) including the administration of a fast-acting insulin medication(#1) and a supplement and a medication used to treat an overactive bladder (#2).	C 342			

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C 342	Continued From page 18 The findings are: 1. Review of Resident #1's current FL-2 dated 07/16/24 revealed: -Diagnoses included hyponatremia, major depression, and mild intellectual disability. -There was an order for Humalog (fast acting insulin) 5 units, three times daily before meals and 5 units at bedtime if the resident's finger stick blood sugar (FSBS) was greater than 150. Review of Resident #1' August 2024 medication administration record (MAR) from 08/01/24 to 08/31/24 revealed: -There was an entry for Humalog 5 units, three times daily before meals and 5 units at bedtime if the resident's FSBS was greater than 150 with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation that 5 units of Humalog were administered at 8:00pm from 08/01/24 to 08/31/24. Review of Resident #1's August 2024 FSBS log revealed: -Resident #1's FSBS was less than 150 on 08/02/24, 08/05/24, 08/06/24, 08/10/24, 08/14/24, 08/15/24, 08/19/24, 08/22/24, 08/23/24, 08/25/24, 08/26/24, and 08/28/24 at 8:00pm. -There was documentation no Humalog insulin was administered on these dates. Review of Resident #1's September 2024 MAR revealed: -There was an entry for Humalog 5 units, three times daily before meals and 5 units at bedtime if the resident's FSBS was greater than 150 with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation that 5 units of	C 342	HUMPHREY FAMILY CARE makes every effort to operate in substantial compliance with state regulations. Nothing in this Plan of Correction is an admission otherwise. HUMPHREY FAMILY CARE is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. It is the facility's policy to ensure that medication administration records (MARs) are accurate and include all required elements as specified in 10A NCAC 13G .1004(j). Corrective Action for Affected Residents: On 10/08/24, the following corrective actions were implemented: • Resident #1's MAR was immediately corrected to accurately reflect the administration of Humalog insulin based on FSBS readings. • Resident #2's MAR was corrected to show one entry for Desmopressin acetate, eliminating the duplicate entry. • Resident #2's Vitamin D2 administration schedule was corrected to reflect accurate once-weekly administration. • All affected residents' medication orders were verified with the pharmacy to ensure accuracy. Identifying other Residents having the Potential to be Affected: On 10/08/24, the Director of Care conducted a 100% audit of all current residents' MARs to identify any similar documentation discrepancies, particularly focusing on insulin orders, weekly medications, and potential duplicate entries. Measures put into place or Systemic Changes: 1. By 10/15/24, the Administrator will implement the following: • Updated MAR documentation policy requiring immediate verification of medications against pharmacy records • New procedure for weekly medication administration documentation • Protocol for handling duplicate MAR entries • Revised insulin administration documentation process 2. By 10/22/24, all medication administration staff will receive comprehensive training on: • Proper MAR documentation procedures • Insulin administration documentation requirements • Protocol for handling medication errors and documentation discrepancies • Procedure for requesting new MARs from pharmacy when needed Plan to Monitor Performance: 1. The Director of Care will conduct daily MAR audits for 2 weeks, then three times weekly for 2 weeks, then weekly for 4 weeks, focusing on: • Insulin administration documentation accuracy • Weekly medication documentation • Proper documentation of medication exceptions • Absence of duplicate entries 2. The Administrator will conduct monthly pharmacy reconciliation reviews to ensure accuracy of medication orders and MAR documentation. 3. Results of all audits will be reviewed during monthly Quality Assurance meetings for three months to ensure sustained compliance. The Administrator will report monitoring plan results to the Quality Assurance Committee. The Quality Assurance Committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. Date of Compliance: 10/22/24	10/22/2024

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C 342	Continued From page 19 Humalog were administered at 8:00pm from 09/01/24 to 09/30/24. Review of Resident #1's September 2024 FSBS log revealed: -Resident #1's FSBS was less than 150 on 09/13/24, 09/15/24, and 09/19/24 at 8:00pm. -There was documentation no Humalog insulin was administered on these dates. Review of Resident #1's October 2024 MAR from 10/01/24 to 10/07/24 revealed: -There was an entry for Humalog 5 units, three times daily before meals and 5 units at bedtime if the resident's FSBS was greater than 150 with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation that 5 units of Humalog were administered at 8:00pm from 10/01/24 to 10/06/24. Review of Resident #1's October 2024 FSBS log revealed: -Resident #1's FSBS was less than 150 on 10/01/24, 10/02/24, 10/05/24, and 10/06/24 at 8:00pm. -There was documentation no Humalog insulin was administered on these dates. Observation of medications on hand on 10/07/24 at 11:23am revealed there was a vial of Humalog and syringes available to be administered. Interview with the Supervisor-in-Charge (SIC) on 10/07/24 at 4:38pm revealed: -She would not know looking at Resident #1's MAR if she administered 5 units of Humalog at 8:00pm. -She would only know if she administered the Humalog or not based on what she documented	C 342		

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C 342	Continued From page 20 on the facility's FSBS log. -If she did not administer Resident #1's Humalog, she should have circled her initials and documented on the back of the MAR what the exception was. -She "just missed circling her initial." Interview with an Administrator on 10/07/24 at 3:32pm revealed: -If a medication was not administered the SIC, should document the exception on the back of the MAR. -She tried to audit the MARs every other month. -She had not audited the MARs since July 2024. 2. Review of Resident #2's current FL-2 dated 08/02/24 revealed diagnoses of schizophrenia, hypothyroidism, and overactive bladder. a. Review of Resident #2's current FL-2 dated 08/02/24 revealed an order for Vitamin D2 (a supplement) 50,000 units (used as a supplement) once weekly. Review of Resident #2's August 2024 medication administration record (MAR) revealed: -There was an entry for Vitamin D2 50,000 units once weekly with a scheduled administration time of 8:00am. -There was documentation Vitamin D2 50,000 was administered on 08/05/24, 08/10/24, 08/16/24, and 08/20/24. Observation of medication on hand on 10/07/24 at 4:00pm revealed a multi-dose bubble pack with Vitamin D2 50,000 units was only in one bubble pack per week; the Vitamin D2 would be in the bubble pack administered on Mondays. Telephone interview with a representative from	C 342			

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD 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 342	Continued From page 21 the facility's contracted pharmacy on 10/07/24 at 2:57pm revealed: -Resident #2's Vitamin D2 50,000 units was only dispensed once weekly. -The facility was dispensed 4 weekly packets of medication, and each week only contained one tablet of Vitamin D2 and it was always on the same day to be administered. -She did not know what day the medication would be administered because it depended on what day the medication packet was started at the facility, but it would be the same day every week. Interview with the Supervisor-in-Charge (SIC) on 10/07/24 at 4:38pm revealed: -She did not administer Resident #2's Vitamin D because the medication was not administered on the days she worked. -She had accidentally documented administering Resident #2's Vitamin D one time but she had circled her initials and documented on the back the error. Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She expected the SIC to match the medications on hand to the MAR before administering medication. -Once the medication was administered, the SIC should immediately document the administration on the MAR. -If the SIC was documenting on the MAR as soon as the medication was administered, there would have been no errors with the documentation. Attempted telephone interview with a second SIC on 10/07/24 at 2:33pm was unsuccessful. b. Review of Resident #2's current FL-2 dated 08/02/24 revealed an order Desmopressin (used	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD 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 342	Continued From page 22 to treat an overactive bladder) acetate 0.2mg, take two tablets at bedtime. Review of Resident #5's August 2024 medication administration record (MAR) revealed: -There was an entry for Desmopressin acetate 0.2mg daily with a scheduled administration time of 8:00pm. -There was documentation Desmopressin acetate 0.2mg was administered daily from 08/01/24 to 08/31/24 at 8:00pm. -There was a second entry for Desmopressin acetate 0.2mg daily with a scheduled administration time of 8:00pm. -There was documentation Desmopressin acetate 0.2mg was administered daily from 08/01/24 to 08/31/24 at 8:00pm. Observation of medication on hand on 10/07/24 at 4:00pm revealed a multi-dose bubble pack with Desmopressin Acetate 0.2mg and two tablets were in the bubble pack to be administered at 8:00pm; there were no other Desmopressin on hand. Interview with the Supervisor-in-Charge (SIC) on 10/07/24 at 4:38pm revealed: -She had seen Resident #2's Desmopressin listed on the MAR twice and had questioned it. -The Desmopressin was listed twice because on a different page of the MAR a medication was discontinued, and the pharmacy sent a new MAR. -The new MAR had the Desmopressin listed and the SICs were already documenting on the other page of the MAR that had the medication listed. -She should have marked through one of the entries and documented the entry as a duplicate. -She should not have documented on both entries.	C 342			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HUMPHREY FAMILY CARE

**6245 BURTON CHAPEL ROAD
MEBANE, NC 27302**

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C 342	Continued From page 23 Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She expected the SIC to match the medications on hand to the MAR before administering medication. -If the MAR was not correct the SIC should immediately call the pharmacy to ask for a new MAR to be sent to the facility. -The SICs should not write on the MAR but should have requested a new MAR from the pharmacy, even for a duplicate entry.	C 342		