

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/17/2024
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 Report by Jonathan Gamsey DHSR Construction Section conducted a Biennial Follow-up September 17, 2024 from 08:30 AM to 09:05 AM at the above referenced facility. At the time of the survey, not all deficiencies were corrected therefore further action is required. Additional deficiencies were also observed. NOTES: 1.) At the time of our visit, we cited deficiencies that require an acceptable plan of correction. All deficiencies listed were discussed with onsite staff during the exit interview. There were previous deficiencies that were not closed out from an open biennial survey, these deficiencies were brought forward from previous survey. 2.) Take actions to correct all listed deficiencies, once completed provide verification in the form of photos, receipts, invoices, etc. for all work performed.	{C 000}	HUMPHREY FAMILY CARE makes every effort to operate in substantial compliance with all applicable regulations. HUMPHREY FAMILY CARE's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to maintain current sanitation and fire and building safety inspection reports, including sewage pumping records, in the facility and make them available for review in accordance with 10A NCAC 13G .0302(n). Corrective Action for Affected Residents: On [11/15/2024], the Administrator contacted the sewage pumping service provider and obtained copies of all previous pumping records. These records have been placed in a designated binder in the Administrator's office for easy access and review. Identifying other Residents having the Potential to be Affected: All residents have the potential to be affected by the lack of proper documentation of sewage system maintenance. A complete review of all required sanitation and safety records was conducted on [11/15/2024] to ensure all other required documentation is present and properly maintained. Measures put into place or Systemic Changes: 1. On [11/15/2024], the Administrator created a new filing system specifically for maintaining all sanitation and safety records, including sewage pumping documentation. 2. A new policy was implemented on [11/15/2024] requiring that copies of all sewage pumping records be obtained immediately following service and filed in the designated binder. 3. The Administrator will maintain a tracking log for all required inspections and service records, including sewage pumping schedules. 4. Staff in-service training was conducted on [11/15/2024] to educate all administrative staff about the importance of maintaining these records and the new filing system. Plan to Monitor Performance: 1. The Administrator will conduct weekly audits of the sanitation and safety records binder for the first month, then monthly thereafter, to ensure all required documentation is present and properly filed. 2. The Maintenance Director will maintain a preventive maintenance calendar that includes scheduled dates for sewage pumping and will verify that documentation is received and filed after each service. 3. Results of these audits will be documented on a monitoring form and reviewed during monthly Quality Assurance meetings. 4. Any identified issues will be addressed immediately, and additional staff training will be provided as needed. The Administrator will report monitoring plan results to the Quality Assurance Committee monthly. The Quality Assurance Committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. Date of Compliance: [11/10/2024]	11/10/2024
C 117	Have Current San. And Fire Safety Approvals SECTION .0300 - THE BUILDING 10A NCAC 13G .0302 DESIGN AND CONSTRUCTION (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review. This Rule is not met as evidenced by: 1.) At the time of the survey, it was observed that the facility could not produce the pumping records for the sewage and the liquid wastes from the facility. This is not compliant with the rule. Take	C 117		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5899

F9G324

TITLE

(X6) DATE

If continuation sheet 1 of 6

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C 117	Continued From page 1 the necessary steps to keep records on-site for review.	C 117	HUMPHREY FAMILY CARE makes every effort to operate in substantial compliance with Family Care Home 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. This Plan of Correction constitutes HUMPHREY FAMILY CARE's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that all cooking units must be mechanically ventilated to the outside or be equipped with an unvented, recirculating fan provided with any special filter per manufacturers' instructions for ventless use, in accordance with 10A NCAC 13G .0307(b). Corrective Action for Affected Residents: On 11/15/2024, the Administrator contacted a licensed HVAC contractor to assess and install an appropriate mechanical ventilation system above the stove. The installation of a new range hood with proper mechanical ventilation to the outside will be completed by 11/15/2024. Identifying other Residents having the Potential to be Affected: All residents have the potential to be affected by the lack of proper kitchen ventilation. The Administrator conducted a full facility environmental assessment on 11/15/2024 to ensure no other ventilation issues exist in the facility. Measures put into place or Systemic Changes: 1. By 3/1/2024, a new mechanical ventilation system will be installed above the stove by a licensed HVAC contractor. 2. By 3/5/2024, the Maintenance Director will develop and implement a monthly environmental inspection checklist that includes verification of proper kitchen ventilation system operation. 3. By 3/5/2024, the Administrator will provide in-service training to all staff regarding the importance of reporting maintenance issues immediately, including ventilation system problems. 4. The Administrator will implement a preventive maintenance schedule for the ventilation system as per the manufacturer's recommendations. Plan to Monitor Performance: 1. The Maintenance Director will inspect the kitchen ventilation system weekly for the first month, then monthly thereafter, documenting findings on the environmental inspection checklist. 2. The Administrator will review the environmental inspection checklist monthly to ensure completion and address any identified issues. 3. Any ventilation system issues will be addressed immediately through work orders and tracked to completion. 4. The Quality Assurance Committee will review ventilation system maintenance records quarterly to ensure ongoing 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 Completion: 11/15/2024	11/15/2024
{C 125}	Kitchen-Range Hood SECTION .0300 - THE BUILDING 10A NCAC 13G .0307 KITCHEN (b) The cooking unit shall be mechanically ventilated to the outside or be an unvented, recirculating fan provided with any special filter per manufacturers' instructions for ventless use. This Rule is not met as evidenced by: 1.) At the time of the survey, it was observed that the mechanical ventilation above the stove is missing. This is not compliant with the rule. Take the necessary steps to install a mechanically ventilated vent above the stove. This deficiency was previously cited during our 2024 biennial follow up survey and action hasn't been taken to address the deficiency	{C 125}		
{C 169}	Fire Safety-Smoke Detectors SECTION .0300 - THE BUILDING 10A NCAC 13G .0316 FIRE SAFETY AND DISASTER PLAN (b) The building shall be provided with smoke detectors as required by the North Carolina State Building Code and U.L. listed heat detectors connected to a dedicated sounding device located in the attic and basement. These detectors shall be interconnected and be provided with battery backup. Note: Smoke detectors are required to be interconnected by this Rule. The application of the Rule permits the heat detectors to be interconnected with smoke detectors, but does not require it.	{C 169}	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. This Plan of Correction constitutes HUMPHREY FAMILY CARE's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that all cooking units must be mechanically ventilated to the outside or be equipped with an unvented, recirculating fan provided with any special filter per manufacturers' instructions for ventless use, in accordance with 10A NCAC 13G .0307(b). Corrective Action for Affected Residents: On 2/15/2024, the Administrator contacted a licensed HVAC contractor to assess and install an appropriate mechanical ventilation system above the stove. The installation of a new range hood with proper mechanical ventilation to the outside will be completed by 3/1/2024. Identifying other Residents having the Potential to be Affected: All residents have the potential to be affected by the lack of proper kitchen ventilation. The Administrator conducted a full facility environmental assessment on 11/15/2024 to ensure no other ventilation issues exist in the facility. Measures put into place or Systemic Changes: 1. By 11/15/2024, a new mechanical ventilation system will be installed above the stove by a licensed HVAC contractor. 2. By 11/15/2024, the Maintenance Director will develop and implement a monthly environmental inspection checklist that includes verification of proper kitchen ventilation system operation. 3. By 11/15/2024, the Administrator will provide in-service training to all staff regarding the importance of reporting maintenance issues immediately, including ventilation system problems. 4. The Administrator will implement a preventive maintenance schedule for the ventilation system as per the manufacturer's recommendations. Plan to Monitor Performance: 1. The Maintenance Director will inspect the kitchen ventilation system weekly for the first month, then monthly thereafter, documenting findings on the environmental inspection checklist. 2. The Administrator will review the environmental inspection checklist monthly to ensure completion and address any identified issues. 3. Any ventilation system issues will be addressed immediately through work orders and tracked to completion. 4. The Quality Assurance Committee will review ventilation system maintenance records quarterly to ensure ongoing 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 Completion: 11/15/2024	11/15/2024

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{C 169}	Continued From page 2 This Rule is not met as evidenced by: 1.) At the time of the follow-up survey it was observed that the current heat detectors in the attic were not functional and are fixed at 135 degrees Fahrenheit. Take the proper steps to bring the heat detectors back into compliance. NOTE: the provided Heat Detector(s) are currently disabled and are not at the proper rating of 135 degree rate to rise. This is not compliant with the rule. Take the necessary steps to replace the improper heat detectors with new to ensure that there will properly notify all occupants in the event of a fire or other emergencies. All heat detectors need to be connected to a dedicated sounding device and be either a 135 degree rate of rise device or a 194 degree fixed heat detector. This deficiency was previously cited during our 2023 biennial survey and action hasn't been taken to address the deficiency.	{C 169}	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 functional heat detectors in the attic that are properly connected to a dedicated sounding device and meet the required specifications of either 135-degree rate of rise or 194-degree fixed temperature, in accordance with 10A NCAC 13G .0316(b). Corrective Action for Affected Residents: All residents have been affected by this deficiency. On [11/15/2024], the Administrator contacted a licensed fire safety contractor to replace the non-functional heat detectors in the attic. New UL-listed heat detectors with 135-degree rate of rise capability were installed on [11/15/2024] and verified to be properly connected to the dedicated sounding device with battery backup. Identifying other Residents having the Potential to be Affected: All current and future residents have the potential to be affected by this deficiency. A complete facility-wide inspection of all heat detectors was conducted on [11/15/2024] by the licensed contractor to ensure all other detection devices are functioning properly and meet requirements. Measures put into place or Systemic Changes: 1. The Administrator has implemented a new preventive maintenance schedule for testing all heat detectors monthly. 2. A contract has been established with [Fire Safety Company] for quarterly inspections of all fire safety equipment, including heat detectors. 3. The Maintenance Director completed training on [11/15/2024] regarding proper heat detector specifications and testing procedures. 4. A new documentation system has been implemented to track all fire safety equipment inspections and maintenance. 5. The facility's fire safety policy has been updated to include specific requirements for heat detector specifications and maintenance. Plan to Monitor Performance: 1. The Maintenance Director will conduct monthly testing of all heat detectors and document results in the fire safety log. 2. The Administrator will review the fire safety logs weekly for the first month, then monthly thereafter. 3. Quarterly professional inspections will be documented and reviewed by the Administrator. 4. Any identified issues will be addressed immediately with documentation of corrective actions taken. 5. The Quality Assurance Committee will review fire safety compliance quarterly to identify any patterns or trends requiring additional intervention. The Administrator will report monitoring results to the Quality Assurance Committee monthly until substantial compliance is achieved and maintained for three consecutive months. The completion date for all corrective actions is [11/15/2024].	11/15/2024
{C 174}	Building Equipment Maintained Safe, Operating SECTION .0300 - THE BUILDING 10A NCAC 13G .0317 BUILDING SERVICE EQUIPMENT (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. (j) This Rule shall apply to new and existing family care homes. This Rule is not met as evidenced by: 2.) At the time of the survey, it was observed that the bathroom floor near the right side of the facility is cracked and soft around the toilet. This	{C 174}		

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{C 174}	Continued From page 3 is not compliant with the rule. Take the necessary steps to resolve the soft flooring and fasten the toilet or contact a qualified professional to resolve the issue. *At the time of the follow-up survey the previously cited deficiency has not been corrected. This deficiency was previously cited during our 2023 biennial survey and action hasn't been taken to address the deficiency This deficiency was previously cited during our 2024 biennial survey and action hasn't been taken to address the deficiency This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency 3.) At the time of the survey, it was observed that the hall smoke detector was not interconnected so when one smoke detector goes off all devices in the building alarm. This is not compliant with the rule. Take the proper steps to have all smoke connectors interconnected and or reach out to a qualified professional to resolve the issue. This deficiency was previously cited during our 2023 biennial survey and action hasn't been taken to address the deficiency. This deficiency was previously cited during our 2024 biennial survey and action hasn't been taken to address the deficiency. This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency. 4.) At the time of the survey, it was observed the dryer hose was crimped. This is not compliant with the rule. Take the proper steps to ensure the dryer hose has clearance to function as intended. This deficiency was previously cited during our 2023 biennial survey and action hasn't been	{C 174}	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 maintain all building and fire safety, electrical, mechanical, and plumbing equipment in a safe and operating condition in accordance with 10A NCAC 13G .0317. Corrective Action for Affected Residents: By 11/15/2024, the following corrections will be completed: • A licensed plumber will repair the bathroom floor and toilet on the right side of the facility • A licensed electrician will properly interconnect all smoke detectors • The dryer hose will be properly repositioned and replaced if needed • The attic door will be repaired to ensure proper closure • The building exterior will be professionally power washed • The loose exterior outlet will be properly secured by a licensed electrician • The loose railing to the laundry room will be securely fastened • The damaged cover plates near the attic access door will be replaced • The damaged ceiling area will be repaired by a qualified contractor Identifying other Residents having the Potential to be Affected: All residents have the potential to be affected by these maintenance issues. The Administrator conducted a full facility inspection on 11/15/2024, to identify any additional maintenance issues requiring attention. Measures put into place or Systemic Changes: 1. The Administrator has established a preventive maintenance program that includes: • Weekly building inspection checklist implementation • Quarterly professional inspections of all safety equipment • Creation of a maintenance log to track repairs and completion dates • Implementation of a vendor management system for tracking professional services 2. Staff training will be conducted by 11/15/2024 , on: • Daily environmental rounds requirements • Proper reporting procedures for maintenance issues • Emergency maintenance protocols Plan to Monitor Performance: 1. The Maintenance Supervisor will: • Conduct daily rounds to inspect building conditions • Complete weekly maintenance checklists • Document all repairs in the maintenance log 2. The Administrator will: • Review maintenance logs weekly • Conduct monthly facility-wide inspections • Verify completion of all repairs 3. Quality Assurance monitoring will include: • Monthly review of maintenance logs • Quarterly facility inspection reports • Review of any resident complaints related to facility maintenance The Administrator will report monitoring results to the Quality Assurance Committee monthly for six months or until substantial compliance is achieved and maintained. The completion date for all corrective actions is 11/15/2024	11/15/2024

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{C 174}	Continued From page 4 taken to address the deficiency. This deficiency was previously cited during our 2024 biennial survey and action hasn't been taken to address the deficiency. This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency. 8.) At the time of the Follow-up survey, it was observed that the attic door was no longer working as intended "closing flush with the ceiling". This is not compliant with the rule. Take the proper steps to repair/replace the attic door. This deficiency was previously cited during our 2024 biennial survey and action hasn't been taken to address the deficiency. This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency. 10.) At the time of the Follow-up survey, it was observed that the exterior of the building is not being properly maintained. This is not compliant with the rule. Take the proper steps to power wash the building and or hire an exterior service to assist. This deficiency was previously cited during our 2024 biennial survey and action hasn't been taken to address the deficiency. This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency. 11.) At the time of the Follow-up survey, it was observed that the exterior outlet next to the office exit door is loose in its opening. This is not compliant with the rule. Take the proper steps to fasten the outlet to the wall and or hire a qualified professional to resolve the issue. This deficiency was previously cited during our	{C 174}		

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{C 174}	Continued From page 5 2024 biennial survey and action hasn't been taken to address the deficiency. This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency. 12.) At the time of the survey, it was observed that the railing leading up to the laundry room was loose. This is not compliant with the rule. Take the necessary steps to repair and or replace. This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency. This deficiency was previously cited during our 2024 biennial follow-up survey and action hasn't been taken to address the deficiency. New Deficiencies 13.) At the time of the survey, it was observed that the two cover plates to the left and right of the attic access door were damaged. This is not compliant with the rule. Take the necessary steps to replace the cover plates as needed. 14.) At the time of the survey, it was observed that the ceiling was damaged directly left of the access door. This is not compliant with the rule. Take the necessary steps to repair the ceiling.	{C 174}		