STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL034092	A. BUILDING: _____ B. WING _____	09/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAMU'S FAMILY CARE HOME	1251 SHELTER COVE WINSTON-SALEM, NC 27106

(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 conducted a annual survey on September 9, 2026.	C 000		
C 107	10A NCAC 13G .0317 (f) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (f) Where there is live-in staff in a family care home, a hard-wired, electrically operated call system meeting the following requirements shall be provided: (1) the call system shall connect residents' bedrooms to the live-in staff bedroom; (2) when activated, the resident call shall activate a visual and audible signal in the live-in staff bedroom; (3) a resident call system activator shall be in residents' bedrooms at the resident's bed; (4) the resident call system activator shall be within reach of a resident lying on the bed; and (5) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that a call system connecting each resident bedroom to the staff bedroom was in working order. The findings are: Review of the facility's current license effective 01/01/26 revealed they were licensed for 6 ambulatory residents.	C 107		

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C 107	Continued From page 1 Observation of the facility on 09/09/26 at 8:05am revealed three residents resided in the facility. Observation of the staff bedroom on 09/09/26 at 8:08am revealed: -There was a call system box hanging on the wall of the office with indicators identifying locations of call bells when activated. -The bedroom was located beside the staff office/laundry room. Observation of 3 resident bedrooms on 09/09/26 from 8:10am to 8:25am revealed: -One male resident was assigned to each of the three bedrooms. -All three bedrooms had call-bells, similar to light switches, with a push button in the middle of each panel. Observations of the activated calls bells on 09/09/26 from 8:25am to 8:28 am revealed that each call bell switch did not sound in the staff bedroom, and a light did not indicate the location of each activated call bell. Interview with the resident who resided in bedroom #3 on 09/09/26 at 9:47am revealed: -He had used his call bell before and thought it sounded in the laundry room but could not recall when. -He felt he could get assistance if needed by yelling for help. Interview with the resident who resided in bedroom #2 on 09/09/26 at 9:56am revealed: -He had never used his call bell, so he didn't know if it made a sound anywhere. -He felt confident he could yell for help or get to a staff member in the event of an emergency.	C 107		

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C 107	Continued From page 2 Based on observations, interviews, and record reviews, it was determined that the resident who resided in bedroom #1 was not interviewable. Interview with the Supervisor in Charge (SIC) on 09/09/26 at 12:25pm revealed: -Call bells were tested periodically but he did not know how often or the last time they were tested. -Staff were allowed to sleep at night but were required to complete visual checks on each resident at least 3 times during sleep hours. -Residents used their call bells only occasionally because all 3 could call out for help if needed. -He was unaware the call bell system was not working. Interview with the Administrator on 09/09/26 at 12:46pm revealed: -The call bell system normally sounded in the staff bedroom beside the laundry room. -She found out the call bell system was not working on 09/01/26 when the local county Department of Social Services (DSS) representative visited the facility. -She had called a repair company after the DSS visit but could not recall when. -All three residents were ambulatory, never used the call bell system, and could call out for help if needed. -She expected the current call bell system to be repaired or replaced.	C 107		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration	C 335		

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C 335	Continued From page 3 in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 2 of 3 residents.	C 335		

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C 335	Continued From page 4 The findings are: Observation of the medication storage room on 09/09/26 at 12:15pm revealed: -There was a clear medication dosing cup on the top shelf of the medication storage cabinet containing approximately 5 oral tablets and 1 capsule. -There was a clear medication dosing cup on the middle shelf of the medication storage cabinet containing 1 oral tablet and 1 capsule. -The cups were not covered. -Neither cup was labeled with a resident's name, or a time of administration. -The names of the medications were not listed. Interview with the Supervisor in Charge (SIC) 09/09/26 at 12:25pm revealed: -He administered residents' medications for the day from the prepared medication cups. -Each resident had their own shelf in the medication storage cabinet. -He prepared the medications for each resident when he arrived to work in the mornings and had been doing so every day he worked. -He was not aware that medication containers should be capped or sealed and the containers should be labeled with the name of the medications. -He had been working at the facility for two years. -He was told by the Administrator that he could prepare medications for each resident 24 hours in advance but to prepare only the medications he would be giving while he was working. Interview with the Administrator on 09/09/26 at 12:46pm revealed: -She was aware of the rules concerning medications being prepared in advance of administration.	C 335		

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C 335	Continued From page 5 -She was not aware that staff were preparing medications in advance. -She expected medications to remain in their original packaging until administration.	C 335		
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 3 sampled residents (#1) had an order to self-administer	C 350		

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C 350	Continued From page 6 medication. The findings are: Review of Resident #1's current FL2 dated 05/29/26 revealed: -Diagnoses included: diabetes type II, dementia, hypertension, depression, obesity, ataxia and alcohol Korsakoff syndrome. -There was an order for semaglutide 2mg inject subcutaneously once weekly. Review of Resident #1's record revealed he did not have an order to self-administer any medication from his Primary Care Provider (PCP). Observation of Resident #1's medications on hand on 09/09/26 at 12:20pm revealed there was a box in the facility refrigerator containing three single dose pens of semaglutide 2 mg with a dispense date of 08/24/26. Interview with Resident #1 on 09/09/26 at 10:16am revealed: -He had been administering his own semaglutide injections since his PCP ordered it almost 2 years ago. -Staff would remind him when his injection was due and bring the injection pen to his room. -Staff would attach a disposable needle onto the injector pen for him but he would inject the medication himself. -His PCP never told him he could not administer the medication himself. Interview with the Supervisor in Charge (SIC) on 09/0926 at 10:41am revealed: -Resident #1 administered his own semaglutide injections once weekly.	C 350		

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C 350	Continued From page 7 -He was unaware an order from Resident #1's PCP was needed for self-administration. Interview with the Administrator on 09/09/26 at 12:46pm revealed: -She was not aware that Resident #1 was self-administering his semaglutide injection. -She was aware of the rules regarding self-administration of medications. -She was not aware that Resident #1 had no order to self-administer the medication from his PCP. -She expected staff to administer the injection until a self-administration order could be obtained from Resident #1's PCP. Attempted telephone interview with the facility's contracted pharmacy on 09/09/26 at 12:40pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 09/09/26 at 12:42pm was unsuccessful.	C 350		