

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL067022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/07/2014
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NAME OF PROVIDER OR SUPPLIER PINEWOOD HARBOR	STREET ADDRESS, CITY, STATE, ZIP CODE 325 SOUND ROAD HOLLY RIDGE, NC 28445
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow up survey, and complaint investigation survey on November 6 - 7, 2014. The complaint investigation was initiated by the Onslow County Department of Social Services on November 5, 2014.	D 000		
D 079	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the facility in a clean and orderly manner free of obstructions and hazards for 3 of 6 resident bedrooms, 4 of 5 bathrooms used by residents, the 200 hallway, and the laundry room and free of bed bug infestation.</p> <p>The findings are:</p> <p>Interview with the Housekeeper/Personal Care Aide (HK/PCA) upon arrival at the facility on 11/6/2014 at 10:15am revealed: -The HK/PCA had been employed at the facility for "about three months". -The HK/PCA worked Monday through Friday from 7am to 4pm. -The duties as housekeeper were to clean all</p>	D 079		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 079	<p>Continued From page 1</p> <p>rooms, dust, clean the bathrooms, and ensure paper towels and toilet paper were in the bathrooms.</p> <p>-He did small maintenance duties such as when facility was infested, he took off wallplate covers and replaced them.</p> <p>Observation on the 200 hall on 11/6/2014 at 10:35am revealed: -A large black plastic trash bag tied up and sitting against the wall by room 201. -More than 8 brownish-black spotted areas on the hallway floor in different sizes and shapes in front of the black plastic trash bag sitting against the wall by room 201.</p> <p>Observation of room 201 on 11/6/2014 at 10:35am revealed: -The bed closest to the room door (Bed A) only had a fitted sheet which was approximately ¾ stained with a yellowish-gold color.</p> <p>Observation of the H/C Bath on the left side of the 200 hall on 11/6/2014 at 11:42am revealed: -The bathroom floor was spotted with a dark brownish-black substance from the door to the drain in the center of the floor. -An area on the floor around the toilet was spotted with a dark brownish-black substance that was stuck to the floor. -The inside bottom of the bathtub had a loose dark brownish-black substance from the drain to the center of the bathtub.</p> <p>Interview with the Housekeeper on 11/6/2014 at 11:42am revealed: -The shower and bathtub in the H/C bathroom was out of order. -The bathroom door had been locked and there had been signs posted on the bathroom door</p>	D 079		

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D 079	<p>Continued From page 2</p> <p>about the shower and tub being out of order to keep the residents from using the bathroom, but the residents would take the signs down, unlock the door, and use the bathroom anyway.</p> <p>Observation of room 207 on 11/6/2014 at 11:17am revealed the grill covering to the heater unit was laying on the floor to the right of the heater.</p> <p>Observation of the bathroom between rooms 207 and 209 on 11/6/2014 at 11:17am revealed:</p> <ul style="list-style-type: none"> -The inside of the bathroom sink was covered with small specks of a loose brownish color particle. -The entire inside of toilet bowl was heavily streaked and stained with a dark brownish-black substance. -There was a slippery loose white powdery substance on the floor in front of the toilet. -The tile grout on the floor close to the wall at the bathroom entrance was stained with a dark brownish-black substance. <p>Interview with the Housekeeper on 11/6/2014 at 12:05pm revealed:</p> <ul style="list-style-type: none"> -The resident in room 207 had "messed with the heater". -The toilet had been cleaned on 11/5/2014. -Resident bathrooms were cleaned every other day. -The Housekeeper usually cleaned resident rooms when the residents were at lunch. <p>Observations on the 100 hall with the Administrator on 11/6/2014 at 12:20pm revealed:</p> <ul style="list-style-type: none"> -There were mattresses leaning against the left side of the wall in the hallway. -There was a pile of trash swept up against the right side of the wall of the 100 hall common 	D 079		

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D 079	<p>Continued From page 3</p> <p>bathroom area.</p> <p>Interview with the Administrator on 11/6/2014 at 12:25am revealed: -There were no residents currently living on the 100 hall because the hall was being treated for bedbugs. -Staff had just assisted a resident to bathe in the common bathroom area because the shower in the shower room on the 200 hall was out of order.</p> <p>Observation of the Housekeeper on 11/6/2014 at 12:50pm revealed the housekeeper was cleaning on the 200 hall and going in and out of resident rooms.</p> <p>Observation of the bathroom used by residents in rooms 207 and 209 on 11/6/2014 at 1:05pm revealed: -The toilet bowl remained soiled and stained. -The bathroom floor around the toilet remained with a white slippery powdery substance. -The floor tile remained soiled.</p> <p>Observations on the 200 hall on 11/6/2014 at 4:30pm revealed: -The hallway floor continued to have dirty spots on the floor by room 201. -The toilet bowl and sink in the bathroom used by residents in room 207 and 209 had been cleaned.</p> <p>Observations in the front dayroom on 11/7/2014 at 10:12am revealed the wall to the right of the entrance had a loose wire extending out of a small cut-out in the wall.</p> <p>Observation of the laundry room on 11/7/2014 at 10:40am revealed: -A resident was doing laundry. -The laundry room floor was dirty and wet.</p>	D 079		

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D 079	<p>Continued From page 4</p> <ul style="list-style-type: none"> -The trashcan next to the dryer was filled to the top. <p>Random observations on the 200 hall on 11/7/2014 between 9:30am and 12:30pm revealed:</p> <ul style="list-style-type: none"> -The hallway floor continued to have dirty spots on the floor by room 201. -Bed A in room 201 continued to have the yellow stained sheet covering. -The inside of the toilet bowl in room 205 was stained at the water line, and there were brown circular stains on the top front edge of the toilet bowl. -The grill covering on the heating unit in room 206 was detached from the wall on the right side of the heating unit. -Two electrical outlet covers were missing from outlets on the left wall of room 206. -A soiled incontinent pad lay on the floor to the left of the entrance next to the head of Bed A. There was a blackish colored dead bug on top of the incontinent pad laying on the floor in room 206. <p>Observation of the HK/PCA on 11/7/2014 at 12:15pm revealed the Housekeeper was mopping in the 200 hallway.</p> <p>Interview with the HK/PCA on 11/7/2014 at 12:15pm revealed:</p> <ul style="list-style-type: none"> -He mopped in the facility in the mornings. -The Medication Aide on the night shift was supposed to mop also. By the time the housekeeper came back the next morning, the floors were dirty again. If the same spots were still on the floor on 11/7/2014 as were there on 11/6/2014, that meant the night Medication Aide did not mop. <p>Continued interview with the HK/PCA on</p>	D 079		

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D 079	<p>Continued From page 5</p> <p>11/7/2014 at 12:25pm revealed:</p> <ul style="list-style-type: none"> -First thing in the mornings he swept the bedrooms to the center hall and would then sweep the trash up. -The Housekeeper/PCA would then dust the bedrooms. -The Housekeeper/PCA sprayed a germ killer around the base of the bed. -The Housekeeper/PCA sprayed a germ killer over resident comforters. <p>Confidential interviews with Residents during the survey revealed:</p> <ul style="list-style-type: none"> -The housekeeper did not clean the bathrooms in resident rooms. -The Housekeeper says "he doesn't do bathrooms". -The Housekeeper sweeps the bedroom floor only. -The resident did not like that staff don ' t go near the bathroom to clean. -The Housekeeper says he only sweeps and mop the floor. -Nobody cleans the building when the housekeeper is off on weekends. -The resident swept her own room and hallway on the weekend. <p>Interview with the Administrator on 11/7/2014 at 1:20pm revealed:</p> <ul style="list-style-type: none"> -There was no cleaning schedule for the facility. -The Administrator talked to the Housekeeper/PCA on 11/6/2014 about a cleaning schedule. <p>Interview on 11/7/14 at 2:07pm with a family member of Resident #2 revealed:</p> <ul style="list-style-type: none"> -The resident is visually impaired and hearing impaired. -She noticed when she visited, the resident did 	D 079		

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D 079	<p>Continued From page 6</p> <p>not have bed linens.</p> <ul style="list-style-type: none"> -The resident's room floor "looked like it had not been swept in 4 or 5 months". -There was a television sitting in the middle of the floor (she thought that was very unsafe). -There was black stuff on the wall and she did not want to speculate what it was. -She was offended by the way the resident's personal environment was kept and thought it was not safe and home like. -The unclean disorderly environment contributed to the family's decision to remove the resident from the facility. <p>Confidential interview on 11/6/14 at 10:38am with a resident revealed:</p> <ul style="list-style-type: none"> -She had not seen any bed bugs in the facility in a long time. -She had not been bitten recently by bed bugs. <p>Observation on 11/6/14 at 10:44am of drawers in dresser no bed bugs noted.</p> <p>Interview on 11/6/14 at 11:34am with another resident revealed:</p> <ul style="list-style-type: none"> -She had not seen any bedbugs in the facility in weeks. -She had not been bothered by them recently and had not been bitten. - The exterminator was treating the facility on a regular basis -The facility had treated and stored most of their personal items clothes and allowed them 2 to 3 outfits. <p>Observation on 11/6/14 at 1:45pm of a section of the building where residents no longer lived revealed:</p> <ul style="list-style-type: none"> -Live bed bugs observed in the crevices of a dark 	D 079		

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D 079	Continued From page 7 blue mattress propped against the wall in the closed section of the building. -Live bed bug on the door frame. -Live bed bug on the base board along wall in the hall way of the closed section of the building. Interview on 11/7/14 at 9:44am with the Administrator revealed: -The resident feedback regarding the bed bug infestation there had been improvement. -The exterminator will treat the facility twice per month until the facility is bed bug free. -The exterminator had visited the facility in the last week.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure 2 of 11 resident bedroom heating units and a hot water heater were maintained in a safe and operating condition. The findings are: Observations of the facility on 11/6/2014 during the tour from 10:35am to 12:10pm revealed hot water temperature ranges from 88 degrees Fahrenheit to 156 degrees Fahrenheit. Observation of the Housekeeper/Personal Care	D 105		

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D 105	<p>Continued From page 8</p> <p>Aide (HK/PCA) on 11/6/2014 at 10:48am revealed:</p> <ul style="list-style-type: none"> -The HK/PCA went into a room where two hot water tanks were located. -The HK/PCA identified the hot water tank closest to the mechanical equipment as the hot water tank that controlled the water temperature for the resident bathrooms and shower rooms and the second hot water tank for the kitchen. -The HK/PCA reached up on top of the hot water heater closest to the mechanical room and flipped a switch. A puff sound like something turning on was heard. The housekeeper stated the hot water heater had turned on. <p>Interview with the HK/PCA on 11/6/2014 at 10:48am revealed:</p> <ul style="list-style-type: none"> -The "switch will flip off" if too many people are using the hot water. -The HK/PCA did not know why the switch would flip off. -The HK/PCA was told by an inspector that "older building equipment would do that". <p>Interview with the Administrator on 11/6/2014 at 12:10pm revealed:</p> <ul style="list-style-type: none"> -An electrician was at the facility on 11/5/2014. -The Administrator would call the electrician again. <p>Telephone interview with the Electrician on 11/6/2014 at 12:12pm revealed:</p> <ul style="list-style-type: none"> -He thought it was 2 days ago when he was at the facility. -The electrician "changed out GFI that were not functioning". -The GFI did not affect hot water. -He had not touched the hot water heaters and recalled seeing two hot water heaters. 	D 105		

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D 105	<p>Continued From page 9</p> <p>Observation on 11/6/2014 between 1:05pm and 1:10pm revealed:</p> <ul style="list-style-type: none"> -The housekeeper hit the service switch on top of the hot water heater and a puff sound was heard which sounded like something was turning on. -The housekeeper stated the pilot light to the water heater had come back on. <p>Confidential interviews with residents during the survey revealed:</p> <ul style="list-style-type: none"> -The water temperature is hot. -The water temperature is cold. -The water was cold when the resident got up to take a shower. Staff said the hot water was on. -Sometimes the water temperature is good, but they have to turn on the hot water heater. <p>Observation of the heating unit in room 207 on 11/6/2014 at 11:17am revealed:</p> <ul style="list-style-type: none"> -The heater grill cover was detached from the wall and laying on the floor to the left of the heater. -The heating unit did not make a sound when turned on. -No hot or cold air blew out of the unit when it was turned on by the resident. <p>Observations of the heating unit in room 206 on 11/7/2014 at 10:50am when the resident turned the heating unit on revealed:</p> <ul style="list-style-type: none"> -The heater grill cover was detached from the wall. -The grill cover fit loosely on top of the heater. -A grinding sound came out of the heating unit. -No hot or cold air blew out of the unit. <p>Confidential interviews with residents during the survey revealed:</p> <ul style="list-style-type: none"> -Someone had worked on the heater but did not put it back together. 	D 105		

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D 105	<p>Continued From page 10</p> <ul style="list-style-type: none"> -It got cold in the residents room at night. -The resident could open the blinds during the day to let the sun in. -No heat in the resident's room. -Have told a medication aide that heating unit does not work. -Try to keep roommate warm with an extra sheet on the bed. <p>Observation of two more heating units in resident rooms on 11/7/2014 revealed black tape was used to tape the heating unit grills together.</p> <p>Interview with the HK/PCA on 11/6/2014 at 12:05pm revealed</p> <ul style="list-style-type: none"> - A resident was messing with a heater and tore it up. -Have some aggressive residents who mess with the heaters. -The Housekeeper did not know the heating unit in room 206 was not working. <p>Continued interview with the HK/PCA on 11/7/2014 at 12:25pm revealed:</p> <ul style="list-style-type: none"> -The HK/PCA was not aware of any residents asking for blankets. -No one had ever told the HK/PCA that they were cold. -The HK/PCA was not aware of any heating and air conditioning units that were not working. -The HK/PCA had been told by the Administrator that once Resident #3 started messing with the heating unit, there was nothing the facility could do until the electrician came. <p>Observation of the heating unit in room 207 on 11/7/2014 at 2:15pm revealed the heating unit was blowing out warm air. The grill cover continued to be laying on the floor next to the unit.</p>	D 105		

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D 105	<p>Continued From page 11</p> <p>Interview with the Administrator on 11/7/2014 at 2:50pm revealed: -No residents had voiced to the Administrator they were cold. -The residents may have told staff working they were cold.</p> <p>Interview with a 3-11/11-7 shift Medication Aide (MA) on 11/7/2014 at 3:25pm revealed: -Only one resident had voiced being cold at night. -The MA attributed the resident being cold because the resident was "cold natured."</p> <p>The facility submitted the following Plan of Protection on 11/6/2014: -Pinewood Harbor Administrator contacted a Plumber and Electrician to come to the facility to maintain any machines that are not working properly to accommodate all residents.</p> <p>-Pinewood Harbor will put a procedure in place to assure all residents have proper working equipment. Administrator will also inservice staff and residents on notifying the Administrator in a timely manner that any machine or equipment is not working properly. Administrator will contact Plumber, Electrician and keep a book at nurses station for any issues that may arise and immediately notify proper Technicians.</p> <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 22, 2014.</p>	D 105		
D 113	<p>10A NCAC 13F .0311(d) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the</p>	D 113		

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D 113	<p>Continued From page 12</p> <p>kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures for 5 of 5 fixtures used by the residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F with water temperatures ranging from 88 to 156 degrees F.</p> <p>The findings are:</p> <p>Observations on 11/6/2014 during the facility tour of the revealed: -Hot water temperature at the bathroom sink fixture in room 201 was 88 degrees F at 10:45am.</p> <p>Interview with the Administrator on 11/6/2014 at 10:46am revealed a fire man was working on something in the mechanical room which may be the reason the water temperature was not hot.</p> <p>Interview with the fire man on 11/6/2014 at 10:47am revealed he was not working on anything that would affect the water temperatures.</p> <p>Observation of the Housekeeper/Personal Care Aide (HK/PCA) on 11/6/2014 at 10:48am revealed:</p>	D 113		

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D 113	<p>Continued From page 13</p> <ul style="list-style-type: none"> -The HK/PCA went into a room where two hot water tanks, a washer and dryer, and other mechanical equipment were stored. -The HK/PCA identified the hot water tank closest to the mechanical equipment as the hot water tank that controlled the water temperature for the resident bathrooms and shower rooms and the second hot water tank for the kitchen by the labels on the outside of the hot water tanks. -The HK/PCA reached up on top of the hot water heater closest to the mechanical room and flipped a switch. A puff sound like something turning on was heard. The housekeeper stated the hot water heater had turned on. <p>Interview with the HK/PCA on 11/6/2014 at 10:48am revealed:</p> <ul style="list-style-type: none"> -The "switch will flip off" if too many people using the hot water. -The HK/PCA did not know why the switch would flip off. -The HK/PCA was told by an inspector that older building equipment "would do that". <p>Observations on 11/6/2014 during continuation of the facility tour revealed:</p> <ul style="list-style-type: none"> -Hot water temperature at the bathroom sink shared by rooms 207 and 209 was 142 degrees F at 11:33am with steam. <p>Interview with the HK/PCA on 11/6/2014 at 11:40am revealed:</p> <ul style="list-style-type: none"> -He did not know who checked water temperatures at the facility. -He had just started working at the facility about 2 months ago. -He knew the staff in the kitchen checked the water temperatures in the kitchen. -He had not seen anybody checking water temperatures at the sink fixtures in the resident 	D 113		

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D 113	<p>Continued From page 14</p> <p>rooms.</p> <p>Interview with the Administrator on 11/6/2014 at 11:45am revealed:</p> <ul style="list-style-type: none"> -The kitchen staff checked water temperatures in the kitchen and on the halls. -Water temperatures were checked every day. -Staff were supposed to write the water temperature readings on the water temperature logs. <p>Continued check of water temperatures on 11/6/2014 with the Administrator revealed:</p> <ul style="list-style-type: none"> -At 11:46am the bathroom sink fixture shared by residents in rooms 207 and 209 was turned on. Steam was visible in 20 seconds after turning the fixture on. The water temperature at the bathroom sink shared by residents in rooms 207 and 209 was 142 degrees F at 11:48am. -Hot water temperature at the bathroom sink in room 208 was 132 degrees F at 11:52am. -At 11:55am the bathroom sink fixture shared by residents in rooms 201 and 203 was turned on. Steam was visible immediately after turning the fixture on. The water temperature at the bathroom sink shared by residents in rooms 201 and 203 was 156 degrees F at 11:57am. <p>Observation of facility and surveyor thermometer calibrations on 11/6/2014 at 11:58am revealed:</p> <ul style="list-style-type: none"> -The surveyor thermometer calibrated at 32 degrees F. -The facility thermometer calibrated at 34 degrees F. <p>Recheck of water temperatures together on 11/6/2014 with the Housekeeper and Administrator using facility and surveyor thermometers revealed:</p> <p>Hot water temperature at the bathroom sink</p>	D 113		

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D 113	<p>Continued From page 15</p> <p>shared by rooms 207 and 209 was 132 (surveyor thermometer) and 134 (facility digital thermometer) degrees F at 11:59am with steam.</p> <p>-At 12:02pm, the bathroom sink fixture shared by residents in rooms 201 and 203 was turned on. Steam was visible within 3 seconds of turning the fixture on. The water temperature at the bathroom sink shared by residents in rooms 201 and 203 was 150 (surveyor thermometer) and 152 (facility digital thermometer) degrees F at 11:57am.</p> <p>-At 12:08pm, the bathroom sink fixture used by residents in room 205 was turned on. Steam was visible within 5 seconds of turning the fixture on. The water temperature at the bathroom sink used by residents in room 205 was 136 (surveyor thermometer) and 138 (facility digital thermometer) degrees F at 12:09pm.</p> <p>At 12:10pm on 11/6/2014 the Administrator was requested to post signs at the fixtures cautioning staff and residents of the hot water.</p> <p>Interview with the Administrator on 11/6/2014 at 12:10pm revealed:</p> <p>-The Administrator would have signs posted throughout the facility cautioning staff and residents of the hot water.</p> <p>-An electrician was at the facility on 11/5/2014.</p> <p>-The Administrator would call the electrician again.</p> <p>Interview with the Housekeeper on 11/6/2014 at 12:18pm as he looked at an attachment on the hot water heater revealed:</p> <p>-The gas company sets the temperature of the hot water heaters.</p> <p>-The thermostat was on top of the hot water heater but could not tell what the setting was but looked like it was set at 168 degrees F.</p>	D 113		

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D 113	<p>Continued From page 16</p> <p>Interview with the Administrator on 11/6/2014 at 12:20pm as she looked at the same attachment on the hot water heater revealed: -She could not really see the numbers on the thermostat dial attached to the hot water heater. -The dial in the thermostat was set between 120 and 140 degrees. -The Administrator did not know the facility water temperatures were hot. -The water temperature readings that had been documented on the water temperature logs were 115 - 120 degrees.</p> <p>-Observation on 11/6/2014 at 12:26pm revealed the bathroom sink fixture in the shower room on the right side of the 100 hall used by residents was 132 (surveyor thermometer) and 132.4 (facility digital thermometer) degrees F.</p> <p>Interview with the Administrator on 11/6/2014 at 12:26pm revealed a resident had just showered in the shower room on the right side of the 100 hall with staff assistance.</p> <p>Interview with the Administrator on 11/6/2014 at 12:40pm revealed: -No residents had verbalized any concerns about the water temperature being too hot. -The county Department of Health checked the water temperatures all the time when visits were made and there was nothing about hot water temperatures. -The county Department of Health was last at the facility July 2014.</p> <p>Review of the facility sanitation report dated 7/11/2014 presented by the Administrator revealed the facility was given 2 demerits for lavatory and bathing hot water. A handwritten</p>	D 113		

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D 113	<p>Continued From page 17</p> <p>note on the addendum page of the report read "hot water in some rooms/restrooms 138 - 140 degrees".</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/6/2014 at 12:50pm revealed: -Sometimes the RCC or HK/PCA checked the water temperatures on the resident halls. -The RCC and HK/PCA were checking the hot water temperatures at the fixtures "around the shower area." -The RCC did not know every room hot water fixture needed to be checked.</p> <p>Rechecks of water fixtures on 11/6/2014 used by residents revealed: -At 1:00pm, the hot water temperature at the bathroom sink shared by residents in rooms 201 and 203 was 118 degrees F. -At 1:05pm, the hot water temperature at the bathroom sink shared by residents in rooms 207 and 209 was 110 degrees F.</p> <p>Continued rechecks of the water temperatures on 11/6/2014 used by residents revealed: -At 3:40pm, the hot water temperature at the bathroom sink fixture in room 207 measured 100 degrees F. -At 3:45pm, the hot water temperature at the bathroom sink fixture in room 208 measured 90 degrees F. -At 3:50pm, the hot water temperature at the bathroom sink fixture in room 201 measured 98 degrees F.</p> <p>Recheck of water temperatures on 11/7/2014 revealed: -At 11:28am, the hot water temperature at the bathroom sink fixture in room 205 measured 94 degrees F.</p>	D 113		

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D 113	<p>Continued From page 18</p> <p>-At 11:34am, the hot water temperature at the bathroom sink fixture shared by residents in rooms 201 and 203 measured 100 degrees F (surveyor thermometer) and 101 degrees F (facility thermometer).</p> <p>Review of daily hall water temperature record for September 2014 revealed:</p> <p>-No documented water temperature readings for September 1 - 11, 2014.</p> <p>-On 9/14/2014 a water temperature of 128 degrees was documented. No time or fixture was identified.</p> <p>-On 9/17/2014 a water temperature of 118 degrees was documented. No time or fixture was identified.</p> <p>-On 9/18/2014 a water temperature of 120 degrees was documented. No time or fixture was identified.</p> <p>-On 9/22/2014 a water temperature of 128 degrees was documented. No time or fixture was identified.</p> <p>-On 9/23/2014 a water temperature of 120 degrees was documented. No time or fixture was identified.</p> <p>Review of daily hall water temperature record for October 2014 revealed the hot water temperature readings documented were greater than 116 for 25 of 30 opportunities. Examples are as follows:</p> <p>-On 10/01/2014 a water temperature of 126 degrees at 8am was documented. No fixture was identified.</p> <p>-On 10/02/2014 a water temperature of 124 degrees at "11" was documented. No fixture was identified.</p> <p>-On 10/07/2014 a water temperature of 122 degrees at "1:00" was documented. No fixture was identified.</p> <p>-On 10/12/2014 a water temperature of 129</p>	D 113		

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D 113	<p>Continued From page 19</p> <p>degrees at "3:00" was documented. No fixture was identified.</p> <p>-On 10/18/2014 a water temperature of 122 degrees at "3:00" was documented. No fixture was identified.</p> <p>-On 10/26/2014 a water temperature of 125 degrees at "2:00" was documented. No fixture was identified.</p> <p>-On 10/27/2014 a water temperature of 126 degrees at "12:00" was documented. No fixture was identified.</p> <p>Interview with the kitchen staff on 11/6/2014 at 4:05pm revealed:</p> <p>-He identified his initials as those documented on the daily temperature record for September 2014 and October 2014.</p> <p>-He did not check water temperatures on the resident halls.</p> <p>-He only checked water temperatures in the kitchen or the bathroom across the hall from the kitchen.</p> <p>-He did not know how the water temperature readings got documented for the entire month of November 2014.</p> <p>-He initialed the water temperature readings he documented on the facility water temperature logs.</p> <p>Confidential Interviews with residents revealed:</p> <p>-The water got hot but the resident could adjust the water temperature.</p> <p>-Water temperature was usually cold.</p> <p>-Bathroom sink fixture got hot right away.</p> <p>-When washing hands, the resident would turn on the water and by the time the resident put hands under the water, it was hot. The resident would switch the water over to cold.</p> <p>-The resident had placed hands under sink and puledl back right away because the water was</p>	D 113		

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D 113	<p>Continued From page 20</p> <p>hot. The resident could mix the hot water with cold water.</p> <ul style="list-style-type: none"> -Sometimes the water temperature is good but they have to turn on the water heater. -Hot water gets hotter than normal when they turn on the hot water heater - it's alright, no burns. -The resident got up, took a shower, and water was cold. -If hot water is turned on wide open, it's too hot but after a while it cools down so it won't burn you. -Residents had never told anybody water temperature was too hot. -Never heard any other people say water temperature was hot. <p>_____</p> <p>The facility submitted the following Plan of Protection on 11/06/2014:</p> <ul style="list-style-type: none"> -Facility Administrator contacted the gas company to inquire if facility staff was authorized to touch the thermostats on the hot water heaters, the gentleman stated staff could maintain the thermostat readings. It was just a simple pull on the dial on the temp suitable for residents. -7:00am staff on duty for each day will check the water temps and make sure the readings are 100 - 116 before the residents can use the water to assure safety for each resident. Administrator contacted a plumber who will be at the facility on 11/8/2014 to resolve any issues with the hot water heaters and sinks to assure that the water temps will be safe for resident use. -Caution hot water signs were placed on each resident's bathroom doors and shower rooms. -The facility plan is to put in place a procedure for checking water temps. The Administrator and housekeeping will inservice all staff members on how to take water temps and how to document them correctly. Each day water temps will be 	D 113		

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D 113	Continued From page 21 checked by the 7:00am staff and the housekeeper will check four rooms, document in the water temp book along with date, time, site where water temp was read, and employee signature. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 7, 2014.	D 113		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to assure 1 of 4 staff (Staff A) sampled had been tested for Tuberculosis (TB) disease in compliance with TB control measures adopted by the Commission for Health Services. The findings are: Review of Staff A, Housekeeper/Personal Care Aide employee record revealed: -Staff A's hire date was 10/31/2014.	D 131		

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D 131	<p>Continued From page 22</p> <p>-There was no documentation of TB skin testing for Staff A.</p> <p>Interview with Staff A on 11/7/2014 at 12:25pm revealed:</p> <p>-Staff A had a TB skin test either in April 2014 or July 2014.</p> <p>-Staff A had not had a TB skin test since being employed at the facility.</p> <p>-Staff A volunteered at the facility about 2 ½ months ago.</p> <p>-Staff A was placed on the facility payroll mid to end of October 2014.</p> <p>-Staff A was waiting for the home health nurse to come to the facility to administer the TB skin test.</p> <p>Interview with the Administrator on 11/7/2014 at 1:45pm revealed:</p> <p>-The Administrator was responsible to ensure TB skin testing was done.</p> <p>-The Administrator thought the facility had 2 weeks to get the TB skin test done.</p> <p>-The Administrator did not remember who told her she had 2 weeks to get the TB skin test done.</p> <p>-The Administrator was waiting for the home health nurse to come to the facility to administer the TB skin testing to Staff A.</p> <p>Interview with Staff A on 11/6/2014 at 10:48am revealed the homehealth nurse came to the facility every week to provide care to a resident living at the facility.</p> <p>Observation of Staff A on 11/6/2014 and 11/7/2014 at intervals during the day revealed:</p> <p>-Staff A sat with residents on the porch.</p> <p>-Staff A greeted residents in the hallway of the facility while he performed housekeeping duties.</p> <p>-Staff A went in and out of resident rooms at intervals during the day.</p>	D 131		

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D 131	Continued From page 23 The facility submitted a Plan of Protection on 11/07/2014 as follows: Pinewood harbor LLC has called the nurse liason to come in the facility on Monday, 11/10, 2014 to do TB skin test for all that do not have one up to date. As of 11/7/2014, Pinewood harbor LLC will assure upon employment or living in an adult care home the Administrator and all staff and any live in residents will be tested for TB. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 22, 2014.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interview, and review of personnel files, the facility failed to assure 1 of 4 staff (Staff A) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) according to G.S. 131E-256. The findings are:	D 137		

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D 137	<p>Continued From page 24</p> <p>Review of Staff A's personnel file revealed: -Staff A was hired as a Housekeeper/Personal Care Aide on 10/31/2014. -There was documentation of a Health Care Personnel Registry (HCPR) check completed 11/6/2014. -There was no documentation of a HCPR check completed prior to 11/6/2014.</p> <p>Interview with the Administrator on 11/7/2014 at 4:10pm revealed: -The Administrator or office staff were responsible for completing the HCPR check. -The HCPR check should be done upon hire. -The Administrator had been having computer problems and the office staff had been out of the facility.</p> <p>Observation on 11/6/2014 at 10:15am revealed: -Staff A was working at the facility. -Staff A sat on the front porch with a resident while the resident smoked a cigarette.</p> <p>Interview with Staff A on 11/6/2014 at 10:15am revealed: -Staff A worked as a Housekeeper/Personal Care Aide. -Staff A stated he had been employed at the facility for three months. -Staff A was watching the resident while the resident smoke to make sure the resident did not burn herself, try to stand up, or take off her clothes. -Staff A worked at the facility Monday through Friday from 7am to 4pm.</p> <p>Interview with Staff A on 11/7/2014 at 12:25pm revealed: -Staff A volunteered at the facility about 2 ½ months ago.</p>	D 137		

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D 137	Continued From page 25 -Staff A was placed on the payroll mid to end of October 2014.	D 137		
D 234	<p>10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio</p> <p>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations</p> <p>(a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 3 residents (Residents #2 and #3) were tested for tuberculosis (TB) disease upon admission to the facility according to the control measures adopted by the Commission for Health Services.</p> <p>The findings are:</p> <p>1. Review of Resident #3's current FL-2 dated 4/25/2014 revealed: -Diagnoses included Schizoaffective Disorder - deferred; Bipolar Type, Hypertension, Coronary Artery Disease, PAF, Diabetes Mellitus, Sleep Apnea, Glaucoma, History of Cataract, and Poor Coping. -Resident #3 was admitted to the facility on 5/1/2014.</p>	D 234		

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D 234	<p>Continued From page 26</p> <p>Review of Resident #3's record revealed: --Documentation of a TB [tuberculosis] skin test placed on 09/22/2014 and read as negative on 09/24/2014. -No documentation of any additional TB testing for Resident #3 since admission to the facility.</p> <p>Interview with the Administrator on 11/6/2014 at 4:30pm revealed: -Resident #3 was admitted to the facility from another facility. -Resident #3 came to the facility with a TB skin done. -The TB skin test done at the facility on 9/22/2014 was the only one that had been done at the facility since Resident #3 was admitted. -The Home Health Agency nurse was responsible to administer the TB skin test for the resident. -The Administrator would need to check Resident #3's record for the TB skin test that came with Resident #3 when admitted. -The facility's policy is for any new admission to come with a TB skin test completed.</p> <p>Interview with the Administrator on 11/7/2014 at 1:45pm revealed: -The Administrator had contacted the facility where Resident #3 was admitted from about the TB skin test paperwork she remembered seeing that came with the resident on admission. -The Administrator knew Resident #3 had come to the facility with documentation of a TB skin test.</p> <p>Telephone interview on 11/7/2014 at 2:05pm with the Chief Nurse from the facility where Resident #3 was admitted from revealed: -A TB skin test was placed for Resident #3 on 4/29/2014. -Resident #3 was discharged from the facility on</p>	D 234		

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D 234	<p>Continued From page 27</p> <p>5/1/2014.</p> <ul style="list-style-type: none"> -The TB skin test was not read prior to Resident #3 being discharged. -The TB skin test was to be read by 05/02/2014. -Resident #3 was admitted to their facility from another hospital. -The Chief Nurse did not see any documentation in Resident #3's record of a completed TB skin test. <p>2. Review of Resident #2 ' s current FL-2 dated 5/19/14 revealed:</p> <ul style="list-style-type: none"> -A diagnosis of Partial seizure disorder , Metastatic brain tumor and gait ataxia. -An admission date of 6/3/2014. <p>Review of Resident #2's record revealed:</p> <ul style="list-style-type: none"> --Documentation of a TB [tuberculosis] skin test result dated 10/8/14 and read as negative. -No documentation of any additional TB testing for Resident #2 since admission to the facility. <p>Interview on 11/7/14 at 5pm with the Administrator revealed she did not know why Resident #2's TB test was not done upon admission.</p> <p>Interview on 11/7/14 at 2:07pm with a family member of Resident #2 revealed:</p> <ul style="list-style-type: none"> -Their request for a copy of the resident ' s TB test results had been denied. -She had been told by the Administrator a test had not been done. -The facility was given a notice to discharge on 10/15/14. -The family took the resident home for a visit with family on 10/17/14 and did not return the resident to the facility. 	D 234		

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D 338 D 338	<p>Continued From page 28</p> <p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult 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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, and interviews, the facility failed to treat 4 of 20 residents with dignity and respect related to how staff responded to resident requests and needs.</p> <p>The findings are:</p> <p>Confidential interviews with residents during the survey revealed:</p> <ul style="list-style-type: none"> -The resident was told by Staff D, Medication Aide that the resident had a bad attitude because the resident would "challenge them" and "would go to the Owner with complaints. The resident stated staff resented the resident going to the Owner with complaints. -A resident asked for a pillow several times. The resident believed it was Staff E, Medication Aide who told him to "let your [family member] get you one, she's got all the money" and "you're not getting another pillow, issued you one, go get the rich [family member] to take you to the mall to get you one". -Medication aides are "bossy, several in here that talk hateful to you, just their voice and the way they say it, just got a hateful talk". -Sometimes Staff D, Medication Aide told a resident that the resident was crazy. The resident needed help and called 911 because the resident 	D 338 D 338		

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D 338	<p>Continued From page 29</p> <p>heard voices. The resident felt like the staff did not like the resident.</p> <p>Interview with the Housekeeper/PCA (HK/PCA) on 11/7/2014 at 12:25pm revealed: -The Housekeeper/PCA had never witnessed anyone mistreat a resident. -If a resident had a problem he would try to address it and if not able to address the issue, he would tell the Administrator when available.</p> <p>Interview with the Administrator on 11/7/2014 at 2:50pm revealed: -Residents were told their personal belongings were locked up until the facility had been treated for the recent bedbug infestation. -The Administrator had purchased 2 -3 outfits for each resident when the facility locked up all of the residents belongings to treat the facility for the recent bedbug infestation. -The facility had extra sheets and pillow cases for the residents. -The residents knew there were extra sheets and pillows in the office. -The Administrator was not aware of any resident concerns about being cold at night.</p> <p>Interview with the Administrator on 11/7/2014 at 3:15pm revealed: -The Administrator was told by a resident yesterday that a staff had said to the resident that the staff was not going to get away with something. -The staff member named by the resident was with the construction surveyor at the time the resident said the incident occurred on 11/6/2014. -The Administrator was not aware of any other resident accusations regarding how staff treated a resident. -If a resident tells the Administrator that</p>	D 338		

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D 338	<p>Continued From page 30</p> <p>something has occurred, the Administrator documents it.</p> <p>Interview with the HK/PCA on 11/7/2014 at 3:20pm revealed: -The HK/PCA had not had any interactions with a resident on 11/6/2014. -The HK/PCA was not aware of any concerns with how he talked to residents at the facility.</p> <p>Interview with a Staff E, Medication Aide (MA) on 11/7/2014 at 4:10pm revealed: -The MA was not aware of any staff mistreating a resident at the facility. -The MA would contact the Supervisor and let them deal with the situation if she saw someone mistreat a resident or if a resident told the MA about being mistreated.</p> <p>Interview with a Staff D, Medication Aide (MA) on 11/7/2014 at 5:45pm revealed: -The MA was not aware of any resident complaints about the way staff talked to the residents. -The MA was not aware of any staff talking bad to a resident. -The MA was only aware of a resident complaint on 11/6/2014 regarding another staff member [Staff member named].</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/7/2014 at 5:50pm revealed: -The RCC was not aware of any resident complaints about staff talking bad to the residents. -The Administrator would be responsible to handle any resident complaints.</p>	D 338		

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D 338	<p>Continued From page 31</p> <p>The facility submitted the following Plan of Protection on 11/7/2014:</p> <ul style="list-style-type: none"> -Pinewood Harbor will assure each resident is treated with the utmost respect from each and every staff member. Pinewood Harbor will make sure resident rights are maintained and exercised according to the rules and regulations of the state, will make sure all their needs are met within a timely manner as asked by the resident according to the guidelines of The State of North Carolina. -An in-service will be scheduled on 11/10/2014 on abuse by the Administrator. -Ombudsman will be notified to do an in-service with Residents. -An in-service will be done once a month by a qualified staff. -Pinewood Harbor has a policy if any resident reports to staff any signs of abuse, investigation will immediately take place on the alleged staff member. At any time any findings of abuse are present, staff member will be automatically terminated and reported to Health Care Personnel Registry. Pinewood Harbor at no given time will allow staff to work in facility and not treat residents with respect. Pinewood harbor will make sure all residents are safe and being taken care of according to the guidelines by The State of North Carolina. <p>CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 22, 2014.</p>	D 338		
D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration,</p>	D911		

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D911	<p>Continued From page 32</p> <p>dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to resident rights.</p> <p>The findings are:</p> <p>Based on observations, and interviews, the facility failed to treat 4 of 20 residents with dignity and respect related to how staff responded to resident requests and needs. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].</p>	D911		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide appropriate care and services to residents regarding maintenance of safe hot water temperatures,</p>	D912		

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D912	<p>Continued From page 33</p> <p>maintenance of safe operating equipment, and tuberculosis skin testing of staff.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Based on observations, interviews, and record reviews, the facility failed to assure the hot water temperatures for 5 of 5 fixtures used by the residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F with water temperatures ranging from 88 to 156 degrees F. [Refer to Tag 0113, 10A NCAC 13F .0311(d) Other Requirements (Type A2 Violation)]. 2. Based on observations and interviews, the facility failed to assure 2 of 11 resident bedroom heating units and a hot water heater were maintained in a safe and operating condition. [Refer to Tag 0105, 10A NCAC 13F .0311(a) Other Requirements (Type B Violation)]. 3. Based on record review and interview, the facility failed to assure 1 of 4 staff (Staff A) sampled had been tested for Tuberculosis (TB) disease in compliance with TB control measures adopted by the Commission for Health Services. [Refer to Tag 0131, 10A NCAC 13F .0406(a) Test For Tuberculosis (Type B Violation)]. 	D912		
D934	<p>G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe</p>	D934		

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D934	<p>Continued From page 34</p> <p>practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 3 sampled staff (A,B and C) had state approved infection control training.</p> <p>The findings are:</p> <p>1. Review of Staff A employee record revealed: -The staff was hired 8/2/12. -The staff's job title was Medication Aide. -There was no documentation of infection control training for the staff.</p> <p>2. Review of Staff C employee record revealed: -The staff was hired 6/7/11. -The staff's job title was Medication Aide/ Cook. -There was no documentation of infection control training for the staff.</p> <p>Interview on 11/6/14 at 4:15pm with a Medication Aide revealed she was not aware if she had received infection control training.</p> <p>Interview on 11/7/14 at 5pm with the Administrator</p>	D934		

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D934	Continued From page 35 the infection control training documentation was requested multiple times from the Administrator she revealed: - She stored documentation in various places in the facility. -She had been unable to locate the documentation of the staffs' infection control training.	D934		
D992	G.S.§ 131D-45 Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is	D992		

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D992	<p>Continued From page 36</p> <p>prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure examination and screening for the presence of controlled substances was performed for 1 of 1 staff (Staff A) hired after 10/01/2013.</p> <p>The findings are:</p> <p>Review of the Staff A's personnel record revealed: -Staff A was hired on 10/31/2014 as a housekeeper. -There was no documentation of completion of controlled substance examination and screening.</p> <p>Interview with Staff A, Housekeeper on 11/7/2014 at 12:25pm revealed: -Staff A volunteered at the facility about 2.5 months ago. -Staff A was placed on the facility payroll mid to end of October 2014. -Staff A's position title was Housekeeper/Personal Care Aide. -Staff A signed a paper that the facility could do a random drug screen. -Staff A had not had a drug screen since employment at the facility.</p> <p>Interview with the Administrator on 11/7/2014 at 1:47pm revealed:</p>	D992		

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D992	<p>Continued From page 37</p> <ul style="list-style-type: none"> -Staff A's hire date at the facility was 10/31/2014. -A controlled substance examination and screening had not been completed for Staff A since employment. -The facility did not do pre-employment drug screening. -The Administrator would purchase a drug screening kit from the pharmacy and do a drug screening if there was activity that suggested suspicion of staff. -The Administrator was not aware newly hired staff had to have a controlled substance examination and screening. 	D992		