

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL041075	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2015
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NAME OF PROVIDER OR SUPPLIER ARBOR CARE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 510 BANNER AVENUE GREENSBORO, NC 27401
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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on January 13-15, 2015.	D 000		
D 074	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls, floors and baseboards were clean and in good repair in the pantry, resident's rooms, in the dining rooms and in the hallways.</p> <p>The findings are:</p> <p>Observation during the tour on 1/13/15 from 11:21 a.m. to 1:30 p.m. and from 3:35 p.m. to 4:26 p.m. revealed rooms 53-65 were located on the new wing hall, rooms 49-52 were located on the "little house hall", rooms 43-48 were located on the kitchen hall and rooms 31-42 were located on the west wing hall.</p> <p>Observation of the pantry located inside of the kitchen on 1/13/15 at 11:25 a.m. revealed the linoleum tiled floor in the middle of the pantry was soft.</p> <p>Interview with the Maintenance man on 1/13/15 at 4:35 p.m. revealed: -The Maintenance man had been working at the facility for two months.</p>	D 074		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 074	<p>Continued From page 1</p> <ul style="list-style-type: none"> -The Maintenance man was aware of the soft floor in the middle of the pantry. -The Maintenance man had been aware of the soft area in the pantry floor two weeks ago by a Cook. -The Maintenance man would repair the soft floor in the kitchen's pantry. <p>Observation of room 65 on 1/13/15 at 11:46 a.m. revealed:</p> <ul style="list-style-type: none"> -The baseboards and the corners of the floor had built up black dirt and grime. -The blinds were dusty. <p>Observation of room 64 on 1/13/15 at 11:56 a.m. revealed:</p> <ul style="list-style-type: none"> -The bottom of the door had black marks. -The vent under the window had brown rust. -The area of the wall underneath the window had brown dirt. <p>Observation of room 56 on 1/13/15 at 12:04 p.m. revealed the wall paper had peeled along the wall and beneath the headboards.</p> <p>Observation of dining room, which was located next to room 57, on 1/13/15 at 12:14 p.m. revealed:</p> <ul style="list-style-type: none"> -The baseboards on all four walls had black dried dirt and scum. -The floor vent by the window was stained with brown rust. <p>Observation of room 53 on 1/13/15 at 12:21 p.m. revealed:</p> <ul style="list-style-type: none"> -The floor vent had rust. -The corners of the floor had built-up, dried black dirt. <p>Observation of room 49 on 1/13/15 at 12:22 p.m.</p>	D 074		

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D 074	<p>Continued From page 2</p> <p>revealed:</p> <ul style="list-style-type: none"> -The room smelled like cigarette smoke. -Three cigarette match boxes were on the night stand. -Once cigarette butt was on the floor under the bed and another cigarette butt was located under the round table. -Smearred ashes were on a round table next to the resident's bed. -The floor in the private bathroom had dried dirt around the corners of the floor. <p>Interview with the resident who lived in room 49 on 1/13/15 at 12:22 p.m. revealed Housekeeping cleaned the resident bathroom twice weekly.</p> <p>Observation of room 51 on 1/13/15 at 12:35 p.m. revealed the entrance door had a hole 3 ½ inches wide and 2 inches in length. Wood had chipped from the door.</p> <p>Observation of the common bathroom next to room 52 revealed:</p> <ul style="list-style-type: none"> -The vent located on the wall had rusted. -At least three floor tiles on the floor by the tub were uneven. <p>Observation of the living room wall located on the little house hall on 1/13/15 at 12:41 p.m. revealed:</p> <ul style="list-style-type: none"> -One of the walls behind the bathroom wall had peeling paint. -The floor of the ramp leading out of the little house hall to the new wing hall and the two metal rails on the side of the ramp had peeled paint. <p>Observation of the hall located in front of the kitchen near door #3 on 1/13/15 at 12:46 p.m. revealed:</p> <ul style="list-style-type: none"> -There was one broken tile located on the floor in front of the door. 	D 074		

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D 074	<p>Continued From page 3</p> <ul style="list-style-type: none"> -The floor vent located near the door had black built-up dirt and scum. -The floor in the hall had black built-up scum in the corners of the floor. -Both walls had black markings. <p>Observation of the dining room located across from the kitchen on 1/13/15 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> -All six walls had cracked baseboards. -Black scum was at the bottom of the baseboards. -The tile near one of the entrances of the dining room had 2 holes in the tile, which was ½ inch to 1 inch deep. <p>Observation of the small hall at the entrance to the kitchen on 1/13/15 at 1:16 p.m. revealed:</p> <ul style="list-style-type: none"> -The back of the kitchen door had black markings. -Baseboard was missing on the right side of the hall. <p>Observation of the kitchen hall on 1/13/15 at 3:38 p.m. revealed:</p> <ul style="list-style-type: none"> -Paint had peeled from both walls. -The base boards were dirty with black build up scum. <p>Observation of room 43 on 1/13/15 at 3:56 p.m. revealed in the resident ' s private bathroom, there was a hole in the tiled wall under the sink.</p> <p>Interview with the Resident who lived in room 43 on 1/13/15 at 3:56 p.m. revealed:</p> <ul style="list-style-type: none"> -The hole had been under the sink for three months. -The resident had not reported the hole in the wall to anyone. -Staff did a good job cleaning the facility. 	D 074		

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D 074	<p>Continued From page 4</p> <p>Observation of the dining room on the west wing on 1/13/15 at 4:20 p.m. revealed the baseboards had black stains and the corners of the floor had black built-up scum.</p> <p>Observation of the common bathroom near room 29 on 1/13/15 at 4:24 p.m. revealed rust had stained in the tub on the drainage.</p> <p>Interview with a resident on 1/13/15 at 3:35 p.m. and with another resident on 1/15/15 at 10:45 a.m. revealed both residents did not have a problem with the cleanliness of the facility and housekeeping cleaned the facility daily.</p> <p>Interview with a staff on 1/15/15 at 10:29 a.m., interview with a second staff on 1/15/15 at 5:24 p.m., interview with a third staff on 1/15/15 at 4:25 p.m., and interview with a fourth staff on 1/15/15 at 5:26 p.m. revealed: -Residents had not complained about the cleanliness of the facility. -Staff did not have a problem with the cleanliness of the facility. -Housekeeping cleaned the facility daily.</p> <p>Interview with a Housekeeper on 1/15/15 at 2:41 p.m. revealed: -The cleaning scheduled included the floors were swept and mopped daily. -The resident bathroom floors are cleaned daily. -The walls are cleaned four times a week and as needed. -The doors and the door post and the base boards are cleaned twice weekly. -The blinds are dusted three times weekly.</p> <p>Interview with another Housekeeper on 1/15/15 at 3:01 p.m. revealed:</p>	D 074		

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D 074	<p>Continued From page 5</p> <ul style="list-style-type: none"> -The resident bathrooms are cleaned daily. -The floors are cleaned daily. -The baseboards are cleaned one to two times weekly. -The blinds are dusted three times weekly. <p>Interview with the Resident Care Coordinator on 1/15/15 at 5:00 p.m. revealed:</p> <ul style="list-style-type: none"> -The Director was the Housekeeping Supervisor. -The walls and the floors and baseboards should be cleaned daily and as needed by Housekeeping. <p>Interview with the Director on 1/15/15 at 5:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The Director had been working at the facility for two months. -The Director was the Housekeeping and Maintenance Supervisor. -The floors should be cleaned daily by Housekeeping. -The baseboards should be cleaned twice weekly. -Blinds should be dusted three times weekly. -The Director was aware of what needed to be repaired. -The facility's Maintenance man repaired anything which needed to be repaired such as the holes in the doors, painting and the rusted vents. -Prior to the survey, the Director had scheduled an outside Maintenance crew to assist the facility's Maintenance man with making repairs at the facility the week of 1/18-1/24/15 . <p>Interview with Maintenance on 1/15/15 at 6:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Maintenance repaired anything which needed to be repaired. -Maintenance was aware of some of the repairs at the facility and was currently working on the 	D 074		

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D 074	Continued From page 6 repairs. The Administrator could not be reached at the end of the survey.	D 074		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision related to smoking inside the facility for 2 of 5 sampled Residents (#1, #2), who were known to smoke in the facility.</p> <p>The findings are:</p> <p>1. Resident #1's current FL-2 dated 7/26/14 revealed: -Resident #1's diagnoses included acute respiratory distress, Type II Diabetes Mellitus and hypotension. -Resident #1 was constantly oriented to person, place and time.</p> <p>Record review of Resident #1's Care Plan dated 5/15/14 revealed the resident was independent with all activities of daily living.</p>	D 270		

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D 270	<p>Continued From page 7</p> <p>Review of the Resident Register revealed Resident #1 was admitted to the facility on 12/17/05.</p> <p>Observation of Resident #1's room, which was located on the Little House Hall, on 1/13/15 at 12:22 p.m. revealed: -Resident #1's room smelled like cigarette smoke. -Three cigarette match boxes were on the night stand. -One cigarette butt was on the floor under the bed. -Another cigarette butt was located under the round table and smeared ashes were on top of the round table which was located next to Resident #1's bed.</p> <p>Observation of Resident #1's private bathroom during the same tour of the resident's room on 1/13/15 at 12:22 p.m. revealed: -Two half cigarette butts were inside of the toilet. -Several (at least 12) cigarette black smears were on the toilet seat.</p> <p>Interview with Resident #1 during the same tour on 1/13/15 at 12:22 p.m. revealed: -The resident had been living at the facility for nine years. -The resident smoked outside of the facility in the designated area (West Wing.) -The resident denied smoking inside of the room. -The resident last smoked in the room before Thanksgiving 2014 (11/27/14.) The resident could not remember the date.</p> <p>Further interview with Resident #1 on 1/13/15 at 12:40 p.m. revealed: -The resident did not put the cigarette butts inside of the toilet.</p>	D 270		

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D 270	<p>Continued From page 8</p> <p>-The black cigarette stains were on the toilet seat before the resident moved inside of the room.</p> <p>Further interview with Resident #1 on 1/15/15 at 6:15 p.m. revealed:</p> <p>-The resident had smoked inside of the room on 1/13/15, which was when the resident last smoked inside of the room.</p> <p>-The resident denied smoking inside of the facility when originally asked on 1/13/15, because the resident knew smoking was not allowed inside of the facility.</p> <p>-When the resident smoked inside of the facility, the resident mainly smoked at night during third shift.</p> <p>Review of Resident #1's contract agreement signed by the resident on 12/17/05 revealed:</p> <p>-The facility is a smoke free facility with the exception of designated smoking areas.</p> <p>-Smoking is not permitted in other areas of the building.</p> <p>Interview with two residents on 1/13/15 at 12:35 p.m. and another resident at 12:45 p.m. who stayed on the same hall as Resident #1 revealed they had never seen or known any residents to smoke inside of the facility.</p> <p>Interview with the Director on 1/14/15 at 12:55 p.m. revealed:</p> <p>-Residents are not allowed to smoke inside of the facility.</p> <p>-Residents should smoke in the designated area, which is outside on the west wing.</p> <p>-Resident #1 had received a verbal warning the weekend of 1/9-1/11/15, because staff smelled cigarette smoke inside of the resident ' s room.</p> <p>Observation of the designated smoking area</p>	D 270		

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D 270	<p>Continued From page 9</p> <p>outside in the west wing on 1/15/15 at 6:05 p.m. revealed:</p> <ul style="list-style-type: none"> -A metal cigarette container was located on each side of the ramp. -A metal cigarette container was located by the gazebo. <p>Interview with Resident #1's Nurse Practitioner on 1/15/15 at 10:00 a.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 was a smoker. He encouraged the resident to stop smoking, but the resident refused. -Resident #1 did not need supervision when smoking. -Resident #1 had denied smoking inside of the facility. -There was no residents who lived at the facility who used oxygen. <p>Review of Resident #1's progress note entry dated 9/24/14 (no time) revealed:</p> <ul style="list-style-type: none"> -The first shift Medication Aide (MA) had reported Resident #1 had been smoking inside of the resident's room. -Resident #1 had been warned. <p>Interview with the MA on 1/15/15 at 10:29 a.m., who documented the entry on 9/24/14 revealed:</p> <ul style="list-style-type: none"> -The MA worked 7a.m.-3 p.m. at the facility. -Resident #1 had never been caught smoking inside of the facility. -Staff only smelled the cigarette smoke inside of Resident #1's room. -On 9/24/14 the MA opened Resident #1's room to pass out medications, and the MA smelled cigarette smoke. The MA did not see cigarettes. -The MA warned Resident #1 not to smoke inside of the facility. -The MA told the Resident Care Coordinator (RCC) and the former Director. 	D 270		

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D 270	<p>Continued From page 10</p> <ul style="list-style-type: none"> -Since then the MA had not known Resident #1 to smoke inside of the facility. -Resident #1 keeps the resident's cigarettes and lighter. -The MA checked on the resident every 15 minutes, when she smelled cigarette smoke coming from Resident #1's room. -The MA had never found cigarette butts or cigarette ashes inside of Resident #1's room. <p>Interview with a Housekeeper on 1/15/15 at 2:41 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 would not allow staff to clean the resident's room. -When the Housekeeper emptied Resident #1's trash, the housekeeper found cigarette butts inside of the resident's trash (December 2014.) The Housekeeper did not report the cigarette butts to anyone. <p>Interview with another Housekeeper on 1/15/15 at 3:01 p.m. revealed:</p> <ul style="list-style-type: none"> -The Housekeeper smelled cigarette smoke inside of the Resident #1's room November 2014. -The Housekeeper could not remember the date she smelled the smoke in Resident #1's room. -The Housekeeper told a first shift MA on duty she smelled cigarette smoke inside of Resident #1's room. -The Housekeeper saw ashes on Resident #1's toilet seat July 2014. The Housekeeper could not remember the date. The Housekeeper told a staff on duty, but she could not remember who she told. <p>Telephone interview with Resident #1's family member on 1/15/15 at 3:50 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 was the resident's responsible party. -Resident #1 admitted to smoking inside of the facility on 1/13/15. 	D 270		

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D 270	<p>Continued From page 11</p> <ul style="list-style-type: none"> -Resident #1 told the family member the resident would not smoke inside of the facility again. -Resident #1 had been told many times not to smoke inside of the facility, but the resident had not had any formal warnings for smoking inside of the facility. -Resident #1 mainly smoked inside of the facility around 10:30 a.m., which is when the resident first woke up. -The family member had never seen Resident #1 smoking inside of the facility. -Resident #1 admitted smoking twice inside of the facility. The family member could not remember the first time Resident #1 admitted to smoking inside of the facility. <p>Interview with a MA, who worked first and second shift, on 1/15/15 at 4:25 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 had never been caught smoking inside of the facility. -Staff only smelled cigarette smoke from Resident #1's room. -The MA had never seen ashes or cigarette butts inside of Resident #1's room. -Staff monitored Resident #1 every two hours during rounds. <p>Interview with a Personal Care Aide (PCA), who worked first and second shift, on 1/15/15 at 4:51 p.m. revealed:</p> <ul style="list-style-type: none"> -If a resident is found smoking inside of the room, she report the resident to the supervisor. Staff will do 15 minute checks on the resident for the rest of the shift to make sure the resident is not smoking inside of the room. -The PCA had not been doing 15 minute checks on Resident #1. -The PCA was unaware Resident #1 smoked inside of the resident ' s room. -Resident #1 was checked on every 2 hours 	D 270		

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NAME OF PROVIDER OR SUPPLIER ARBOR CARE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 510 BANNER AVENUE GREENSBORO, NC 27401
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D 270	<p>Continued From page 12</p> <p>during rounds.</p> <p>Interview with the Resident Care Coordinator (RCC) on 1/15/15 at 5:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Resident #1 denied smoking inside of the resident ' s room. -Staff could always smell the cigarette smoke from the resident's room, but staff had never caught the resident smoking inside of the facility. -Resident #1 had been smoking heavily inside of the resident's room for the past three months. -The black stains on the toilet seat inside of Resident #1's private bathroom was there before the resident moved inside of the room. She could not remember when the resident moved to the room. -The RCC had never seen ashes or cigarette butts inside of Resident #1's room. -November 2014 and December 2014 the RCC talked with Resident #1 about smoking inside of the room. -The Director had written Resident #1 up for smoking inside of the room on 1/13/15. The resident was advised next time the resident had been caught smoking inside of the facility, the resident would be issued a discharge notice. -Residents who violate the smoking policy received a verbal warning after the first warning, would be written up after the second warning and would be discharged after the third warning. -Currently, Resident #1 still has cigarettes and a lighter. -Staff are supposed to check on Resident #1 every two hours during rounds. Increased supervision had not been implemented. <p>Review of a note written by the Director dated 1/14/15 revealed:</p> <ul style="list-style-type: none"> -Resident #1 had received a verbal warning for smoking inside of the facility. 	D 270		

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D 270	<p>Continued From page 13</p> <p>-The next time Resident #1 had been caught smoking inside of the facility, the resident would receive a written warning; and if the resident is caught a third time smoking inside of the facility, the resident would receive a 30 day discharge notice.</p> <p>Interview with the Director on 1/15/15 at 5:30 p.m. revealed:</p> <p>-The Director had been working at the facility since the middle of November 2014.</p> <p>-Residents can smoke in the designated areas from 6 a.m. to 12 a.m. At 12 a.m. the doors lock.</p> <p>-If a resident wanted to go outside to smoke after 12 a.m. staff had to go outside with the resident or the resident had to be within viewing distance so staff could monitor the resident.</p> <p>-The first time a resident had been caught smoking inside of the facility, the resident would receive a verbal warning; the second warning would be written warning; and the third warning would be a discharge notice.</p> <p>-A resident would have an immediate discharge if the residents are put in immediate danger.</p> <p>-During a tour of the facility October 2014, the Director smelled cigarette smoke in Resident #1's room.</p> <p>-Resident #1 admitted to the Director smoking inside of the resident's room 1/13/15.</p> <p>-On 1/14/15, Resident #1 had a first official warning for smoking inside of the room.</p> <p>-Currently, staff checked on all of the residents every two hours.</p> <p>The Administrator could not be reached by the end of the survey.</p> <p>2. Review of Resident #2's current FL-2 dated 9/12/14 revealed:</p> <p>-Diagnoses of schizophrenia, depression, and</p>	D 270		

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D 270	<p>Continued From page 14</p> <p>tobacco use disorder.</p> <p>-Resident #2's "Patient Information" under disoriented was left blank.</p> <p>Resident #2's care plan dated 11/22/14 revealed:</p> <p>-Resident #2 was documented as being oriented.</p> <p>-Resident #2 was also documented as having adequate memory.</p> <p>Review of Resident #2's Resident's Agreement dated 10/30/14 and signed by Resident #2's Responsibility revealed:</p> <p>"Effective October 1, 2007, the Community is declared as a smoke free facility. Any person caught smoking inside the building will be directed to extinguish the Lighted smoking products and will be verbally warned. The repetition of such violation will result in written warning follow by issuance of discharge notice from the facility. The smoking area will be opened from 7:00 a.m. 12:00 a.m. midnight."</p> <p>Interview with Resident #2 on 1/13/15 at 3:35 p.m. revealed:</p> <p>-He smoked inside the facility from 1/04-10/15 and it was between the hours of 12:00 a.m. and 3:00 a.m.</p> <p>-After he finished smoking, the resident would placed the cigarettes' butts inside of the toliet in his private bathroom.</p> <p>-He was aware smoking was not allowed in the facility.</p> <p>-He was aware of the facility's designated smoking hours were from 6:00 a.m. to 12:00 a.m.</p> <p>Observation of the shower stall in Resident #2's private bathroom on 1/13/15 at 3:40 p.m. revealed 2 unlit cigarette butts.</p> <p>Observation of the shower stall in Resident #2's</p>	D 270		

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D 270	<p>Continued From page 15</p> <p>private bathroom on 1/14/15 at 3:12 p.m. revealed 1 unlit cigarette butt.</p> <p>Interview with Resident #2 on 1/14/15 at 3:14 p.m. revealed: -The unlit cigarette butts washed up in the shower drain of his private bathroom. -He denied the cigarette butts in the shower stall belonged to him.</p> <p>Interview with Resident #2's physician on 1/15/15 at 10:14 a.m. revealed: -He was aware Resident #2 smoked, but he had not been notified Resident #2 smoked in his room at the facility. -Resident #2 was oriented, and he did not require supervision for smoking outside of the facility.</p> <p>Interview with a personal care aide (PCA) on 1/15/15 at 3:30 p.m. revealed: -Resident #2 smoked inside of the facility almost every night about 2 weeks ago. -Resident #2 smoked on 2nd shift after management left the facility. -PCA caught Resident #2 smoking about 2 weeks ago, and the aide locked up his cigarettes. - She did not report the incident to the supervisor.</p> <p>Interview with a medication aide on 1/15/15 at 3:49 p.m. revealed: -She smelled cigarette smoke in Resident #2's room about a month ago, but she did not see any evidence of cigarettes' butts in the resident's room. -She reported the incident to the supervisor, and Resident #2 denied smoking in his room. -The supervisor talked to Resident #2 about not smoking in his room.</p> <p>Interview with Resident Care Coordinator (RCC)</p>	D 270		

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D 270	<p>Continued From page 16</p> <p>on 1/15/15 at 2:30 p.m. revealed: -She saw an unlit cigarette on the shower stall floor in Resident #2's private bathroom about a week and half ago. -Resident #2 stated, "The unlit cigarette's butt washed up in his private shower stall drain. -She reported no staff or residents reported to her Resident #2 smoked in his room. -The facility had a designate smoking area at the back of the building. -If a resident was caught smoking inside the building, 1st time would get a verbal warning, 2nd time would receive a written warning and 3rd time a 30 day discharge notice.</p> <p>Interview with the facility's Director on 1/15/15 at 3:35 p.m. revealed: -No staff reported to her Resident #2 smoked in his room. -If a resident was caught smoking inside the building, 1st time would get a verbal warning, 2nd time would receive a written warning and 3rd time a 30 day discharge notice.</p> <p>The facility's Administrator was unavailable by phone.</p> <p>Resident #2's Responsible Party was unavailable by phone.</p> <hr/> <p>Review of the facility's Plan of Correction dated January 14 and 15, 2015 revealed: -Effective 1/15/15, all smokers' rooms would be checked by the aides every 2 hours to make sure the residents were not smoking inside of the facility. -If a resident was caught smoking inside the building, 1st time would get a verbal warning, 2nd time would receive a written warning and 3rd time a 30 day discharge notice.</p>	D 270		

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D 270	Continued From page 17 -All staff would be in-serviced by 1/16/15 on checking smokers' rooms every two hours. -All residents who smoke would be notified by 1/16/15 that the aide will check their rooms every 2 hours CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 1, 2015.	D 270		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure the pureed diet was prepared as ordered for 2 of 2 Residents (#7, #8) with orders for pureed diet. The findings are: 1. Review of Resident #7's FL-2 dated 12/4/14 revealed: -The resident's diagnoses included transient cerebral ischemia, generalized weakness and high blood pressure. -Resident #7's diet order included a Regular Pureed diet. Review of Resident Register revealed Resident #7 was admitted to the facility on 12/11/14.	D 310		

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D 310	<p>Continued From page 18</p> <p>Interview with the Cook on 1/13/15 at 11:21 a.m. revealed: -Resident #7 was on a pureed diet. -The Cook prepared the pureed diet.</p> <p>Review of the diet list dated 10/17/14 included the pureed diet for Resident #7.</p> <p>Observation of the preparation of the pureed diet during the lunch meal on 1/13/15 at 11:21 a.m. revealed: -The Cook prepared and portioned 3 ounce (oz) chunky chicken breast, 4 oz chunky green beans, 4 oz chunky rice and 1 slice ground dry bread.</p> <p>Interview with the Cook on 1/13/15 at 11:23 a.m. revealed: -The Cook always prepared the pureed diet chunky. -The Director supervised the kitchen.</p> <p>Observation on 1/13/15 at 11:25 a.m. revealed the Dietary Aide went and got the Director and the Director instructed staff on how to prepare pureed diets.</p> <p>Observation of Resident #7's lunch meal on 1/13/15 at 12:11 p.m. revealed: -Resident #7 was served 3 oz pureed chicken, 4 oz mashed potatoes, 4 oz pureed green beans and 4 oz pureed rice. -The resident did not cough or choke while eating the meal.</p> <p>Observation of Resident #7's dinner meal on 1/14/15 at 5:18 p.m. revealed: -The Cook had prepared and plated 3 oz pureed tuna melt, 4 oz pureed vegetables, 2 oz pureed green pea soup.</p>	D 310		

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D 310	<p>Continued From page 19</p> <p>Interview with the Cook on 1/14/15 at 5:19 p.m. revealed: -The Cook had been working at the facility as a Cook since 1994 and had never been trained on how to prepare the pureed diet. -The first time the Cook was trained on how to prepare the pureed diet was on 1/13/15 by the Director. -The Director advised him the pureed diet should be soft and "look like baby food."</p> <p>Interview with a MA, who worked first and second shifts, on 1/15/15 at 4:40 p.m. revealed Resident #7 had not had any problems when eating the diet.</p> <p>Interview with Resident #7 on 1/15/15 at 4:50 p.m. revealed: -The resident had been on the pureed diet for a couple of months. -The resident had not had any problems with the diet, which included no coughing or choking.</p> <p>Interview with Resident #7's Nurse Practitioner on 1/15/15 at 10:00 a.m. revealed: -Resident #7 was on the pureed diet due to dysphagia. -Resident #7 had not had any problems with aspiration or with the pureed diet. -If a resident had an order for a pureed diet, he expects for the diet to be served as ordered. -The pureed diet should be smooth. -The Nurse Practitioner was not aware Resident #7's diet had not been prepared as ordered.</p> <p>Interview with the Resident Care Coordinator on 1/15/15 at 5:00 p.m. revealed: -The Director supervised dietary. -The pureed diet should look like baby food.</p>	D 310		

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D 310	<p>Continued From page 20</p> <ul style="list-style-type: none"> -The RCC was not aware the pureed diet had not been prepared correctly. -The RCC had observed the pureed diet prepared by the Cook and there was no problems with the preparation of the diet. She did not reveal when she last observed the pureed diet. -Resident #7 had not had any problems with coughing or choking while on the diet. <p>Interview with the Director on 1/15/15 at 5:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The Director had been working at the facility since November 2014. -The pureed diet should be smooth and look like baby food. The diet should not be chunky. -The Director was unaware the pureed diets had been prepared as chunky. -The first time the Director trained the Cook on how to prepare the pureed diet was on 1/13/15, after she was informed the pureed diet was not prepared correctly. -Resident #7 had not had any problems with coughing or choking while eating the diet. <p>The Administrator could not be reached by the end of the survey.</p> <p>2. Resident #8's current FL-2 dated 3/27/14 revealed:</p> <ul style="list-style-type: none"> -Resident #8's diagnoses included high blood pressure and Type II Diabetes Mellitus. The resident had a history of a stroke. -Resident #8's diet order included the pureed diet. <p>A subsequent order dated 11/23/14 revealed a diet order for the Regular pureed diet.</p> <p>Review of Resident #8's physician orders dated 12/18/14 included a diagnosis of dysphagia.</p>	D 310		

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D 310	<p>Continued From page 21</p> <p>Review of Resident Register revealed Resident #8 was admitted to the facility on 3/10/14.</p> <p>Interview with the Cook on 1/13/15 at 11:21 a.m. revealed: -Resident #8 was on a pureed diet. -The Cook prepared the pureed diet.</p> <p>Review of the diet list dated 10/17/14 included the pureed diet for Resident #8.</p> <p>Observation of the preparation of the pureed diet during the lunch meal on 1/13/15 at 11:21 a.m. revealed: -The Cook prepared and portioned 3 ounce (oz) chunky chicken breast, 4 oz chunky green beans, 4 oz chunky rice and 1 slice ground dry bread.</p> <p>Interview with the Cook on 1/13/15 at 11:23 a.m. revealed: -The Cook always prepared the pureed diet chunky. -The Director supervised the kitchen.</p> <p>Observation on 1/13/15 at 11:25 a.m. revealed the Dietary Aide went and got the Director and the Director instructed staff on how to prepare pureed diets.</p> <p>Observation of Resident #8's lunch meal on 1/13/15 at 12:11 p.m. revealed the Cook plated 3 oz pureed chicken, 4 oz mashed potatoes, 4 oz pureed green beans and 4 oz pureed rice.</p> <p>Observation of Resident #8's dinner meal on 1/14/15 at 5:18 p.m. revealed: -The Cook had prepared and plated 3 oz pureed tuna melt, 4 oz pureed vegetables and 2 oz pureed green pea soup.</p>	D 310		

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D 310	<p>Continued From page 22</p> <p>Interview with the Cook on 1/14/15 at 5:19 p.m. revealed: -The Cook had been working at the facility since 1994 and had never been trained on how to prepare the pureed diet. -The first time the Cook was trained on how to prepare the pureed diet was on 1/13/15 by the Director. -The Director advised him the pureed diet should be soft and "look like baby food."</p> <p>Interview with a MA, who worked first and second shifts, on 1/15/15 at 4:40 p.m. revealed Resident #8 had not had any problems when eating the diet.</p> <p>Interview with Resident #8 on 1/15/15 at 4:48 p.m. revealed: -Resident #8 had just started the pureed diet. The resident could not remember when the diet started. -Resident #8 had not had any problems with the diet, which included no coughing or choking. -Resident #8 did not like the diet and preferred the Mechanical Soft diet.</p> <p>Interview with Resident #8's Nurse Practitioner on 1/15/15 at 10:00 a.m. revealed: -Resident #8 was on the pureed diet due to dysphagia. -Resident #8 had not had any problems with aspiration or with the pureed diet. -If a resident had an order for a pureed diet, he expects for the diet to be served as ordered. -The Nurse Practitioner was not aware Resident #8's diet had not been prepared as ordered.</p> <p>Interview with the Resident Care Coordinator on 1/15/15 at 5:00 p.m. revealed: -The Director supervised dietary.</p>	D 310		

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D 310	<p>Continued From page 23</p> <ul style="list-style-type: none"> -The pureed diet should look like baby food. -The RCC was not aware the pureed diet had not been prepared correctly. -The RCC had observed the pureed diet prepared by the Cook and there was no problems with the preparation of the diet. She did not reveal when she last observed the pureed diet. -Resident #8 had not had any problems with coughing or choking while on the diet. <p>Interview with the Director on 1/15/15 at 5:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The Director had been working at the facility since November 2014. -The pureed diet should be smooth and look like baby food. The diet should not be chunky. -The Director was unaware the pureed diets had been prepared as chunky. -The first time the Director trained the Cook on how to prepare the pureed diet was on 1/13/15, after she was informed the pureed diet was not prepared correctly. <ul style="list-style-type: none"> -Resident #8 had not had any problems with coughing or choking while eating the diet. <p>The Administrator could not be reached by the end of the survey.</p>	D 310		
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>	D912		

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NAME OF PROVIDER OR SUPPLIER ARBOR CARE ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 510 BANNER AVENUE GREENSBORO, NC 27401
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(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
D912	<p>Continued From page 24</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to residents smoking inside of the facility.</p> <p>The findings are:</p> <p>Based on observation, interview and record review, the facility failed to provide adequate supervision related to smoking inside the facility for 2 of 5 sampled Residents (#1, #2), who were known to smoke in the facility. [Refer to Tag D270, 10A NCAC 13F .0901 (b). (Type B Violation)]</p>	D912		