

Rec'd via email

PRINTED: 12/29/2014  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL060129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ <i>2/25</i>	(X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  RADBOURNE MANOR III	STREET ADDRESS, CITY, STATE, ZIP CODE 2920 CINDY LANE CHARLOTTE, NC 28269  <i>County: Mecklenburg</i>
---	---

(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
D 000	Initial Comments  The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey on 12/11/14 and 12/12/14.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings  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;  This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls, ceilings, and floors were clean and in good repair in 1 of 1 laundry room, 1 of 1 common full-bathroom, 1 of 4 resident rooms, and 1 of 2 hallway closet doors.  The findings are:  Observation of the facility during tour on 12/11/14 between 9:45 am and 11:50 am revealed:  A. Common full bathroom: -The shower in the common bath had dark brown residue built up on the bottom metal rim of the entrance to the shower. -The shower curtain had reddish brown build-up on the bottom two inches of the curtain. -The right back corner of the shower had build-up of black, brown and reddish residue that appeared to be mold and extended left and right approximately 8 inches vertically on the bottom of the shower where the shower wall meets the shower pan.	D 074	The Administrator & designee on assigned shifts will ensure walls, ceilings and floors are clean and kept in good repair. All ceilings will be cleaned and or painted by 1/26/15. The floors will be cleaned daily, deep cleaning will be done weekly. A daily and weekly cleaning scheduled will be followed by the designee and monitored by the Administrator. The Hallway closet doors will be repaired and or replaced by 1/26/15. The Administrator will monitor weekly to ensure compliance. Administrator developed work order form and will monitor weekly.	

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

*Jelena B Thompson* Administrator

TITLE  
DATE  
1/15/2015

STATE FORM

6659

EAJ11

If continuation sheet 1 of 33

POC Approved  
per B. Moore  
02-13-2015 / *JS*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 074	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-The shower wall had reddish brown build-up on the back bottom wall that extended up four inches with the shower wall panel unsealed from the wall.</li> <li>-A round hole in the sheetrock behind the door in the common bathroom.</li> <li>-Doorknob on the entry door to the common bathroom was loose.</li> <li>-Corner baseboard to the right of the sink was pulled from the wall four inches and wall paint was peeling.</li> </ul> <p>Additional observations on 12/12/14 at 11:42 am of the common bathroom revealed:</p> <ul style="list-style-type: none"> <li>-The dark brown/black/red residues on the metal rims and on the walls and base of the shower were unchanged since 12/11/14</li> <li>-The shower curtain had been cleaned and no reddish brown buildup remained.</li> </ul> <p>Review of the facility's sanitation report dated 03/28/14 revealed demerits for "shower collecting residue on floor and around corners".</p> <p>Interview with a Nurse Aide (NA) on 12/12/14 at 11:40 am revealed:</p> <ul style="list-style-type: none"> <li>-She had only worked at the facility for three days.</li> <li>-Her job duties included mopping residents' rooms daily and cleaning the showers.</li> <li>-She thought there was a cleaning schedule "in the office".</li> <li>-She used shower cleaner which was available.</li> <li>-She had not cleaned the shower curtain since being employed there, but "I know you can take it down and wash it in the washing machine".</li> </ul> <p>Interview with an SIC on 12/12/14 at 1:10 pm revealed:</p> <ul style="list-style-type: none"> <li>-He had worked at the facility since June 2014,</li> </ul>	D 074	<p><i>The Administrator &amp; designee will ensure doorknobs are repaired and or replaced by 1/31/15. Administrator will check knobs weekly. Administrator developed work order form to list if repairs are needed and will monitor weekly.</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 074	<p>Continued From page 2</p> <p>primarily on third shift, but also on first.</p> <ul style="list-style-type: none"> <li>-He was responsible for cleaning the bathrooms, including the showers.</li> <li>-He was aware of the dark buildup in the corner and around the shower floor.</li> <li>-"This is an old building and that could be mold in the shower."</li> <li>-He had washed the shower curtain last night and usually does it weekly by putting it in the washing machine.</li> <li>-He had washed the shower curtain last week, but could not remember which day.</li> </ul> <p>Interview on 12/11/14 at 9:58 am with a resident who resides in Room #4 revealed:</p> <ul style="list-style-type: none"> <li>-He had lived at the facility since 2008.</li> <li>-The black skid marks were made by a recliner that a former resident, who left two weeks ago, had in the room.</li> <li>-The closet door that would not open properly in Room #4 was a former resident's closet.</li> <li>-He used the shower in the common bathroom with staff supervision.</li> <li>-He did not know how often the staff cleaned the shower.</li> </ul> <p>Refer to interview with the Administrator on 12/12/14 at 1:05 pm</p> <p><b>B. Resident Room #4:</b></p> <ul style="list-style-type: none"> <li>-A closet door (the middle of 3 closets) would not close and the top left hinge was pulling out of the door jam with screws exposed.</li> <li>-A round hole approximately 3 inches in diameter in the wall behind the entrance door to Resident Room #4 with white material covering a portion of the hole and appeared to have numerous patches.</li> <li>-Multiple black skid marks on the floor between 2 beds in the resident room.</li> </ul>	D 074		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 074	<p>Continued From page 3</p> <p>Interview on 12/11/14 at 9:58 am with a resident who resides in Room #4 revealed: -He had lived at the facility since 2008. -The black skid marks were made by a recliner that a former resident, who left two weeks ago, had in the room. -The closet door that would not open properly in Room #4 was a former resident's closet. -He used the shower in the common bathroom with staff supervision. -He did not know how often the staff cleaned the shower.</p> <p>Refer to interview with the Administrator on 12/12/14 at 1:05 pm</p> <p>C. Laundry Room -A broken floor tile at the laundry door entrance. -Doorknob on the entry door to the laundry room was loose. -The baseboard was loose around the wall in the laundry room.</p> <p>Refer to interview with the Administrator on 12/12/14 at 1:05 pm</p> <p>D. Hallway Closet Doors: -The door to the Housekeeping Closet would not open or close without force due to the top right hinge pulling out of the door jam with screws exposed, and the bottom of the door scraped on the floor with visible tracks on the floor.</p> <p>Refer to interview with the Administrator on 12/12/14 at 1:05 pm.</p> <p>_____</p> <p>Interview with the Administrator on 12/12/14 at</p>	D 074		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 074	Continued From page 4 1:05 pm revealed: -The facility did have a cleaning schedule that was posted for staff reference, which included cleaning the bathrooms and resident rooms. -The facility did not have a full-time maintenance staff person. -She was aware of the door on the housecleaning closet coming off of the hinges. -She had moved the chemical supplies to the office on 12/11/14. -The building had recently been purchased by the new owners in July 2014 and it had been difficult to financially complete all of the repairs that were left by the previous owners.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities.  This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure that furniture and fixtures, specifically dressers in bedrooms #3 and #4, bathroom fixtures and furniture in the common bath, and dining room chairs were clean and in good repair. The findings are:  Observations in resident bedrooms #3 and #4 on 12/11/14 from 10:15 am to 10:50 am revealed:  -Three residents occupied bedroom #3 and two residents occupied bedroom #4.	D 076	<i>The Administrator will ensure that all furniture and fixtures Specifically dressers in common bath and dining room chairs are cleaned, repaired or replaced by 2/10/15. Due to existing financial obligations, additional time is needed to obtain funds for new fixtures. Administrator will monitor weekly to ensure repairs or replacements are completed timely. Administrator developed a work order form and will monitor weekly.</i>  <i>The Administrator will scheduled a meeting with residents and staff, Asking all if repairs are needed or identified, please put information on Work order form for repairs/or problem by 1/29/15. Staff will be instructed to notify Administrator before shift ends by text or phone call.</i>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL06D129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 076	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-A four-drawer dresser (#1) at the right of the door to Resident Room #4 with the top drawer opened and tilted downward due to having no support and would not open or close easily due to not having glides .</li> <li>-The second and third drawers of dresser #1 were opened slightly and tilted sideways, would not open or close easily due to not having glides, and contained personal contents of a resident in each drawer.</li> <li>-A four-drawer dresser (#2) in Resident Room #4 with the top drawer, filled to the top with resident's clothing, slanted downward and would not open or close easily.</li> <li>-The second drawer in dresser #2 was opened at a slant, contained resident's personal belongings, and would not open or close easily.</li> <li>-A four-drawer dresser (#3) in Resident Room #3 with the top drawer slanted open, all four drawers were off track and would not open or close easily.</li> <li>-A six-drawer dresser (#4) in Resident Room #3 with three drawers on each side had the left middle drawer off track and would not open or close easily.</li> <li>-All drawers in Dresser #4 were empty.</li> <li>-A two-door metal storage cabinet in the common bathroom with extensive rust on the bottom right door, extending the full length of the metal frame on both sides of the doors, and inside the cabinet on the front edge and extending into the base of the cabinet.</li> <li>-A paper towel holder mounted to the right of the sink in the common bathroom was pulling from the wall with one screw fully pulled out and two others ¾ of the way out of the wall.</li> <li>-Approximately 9 feet overhead, was a plastic light fixture cover hanging from the ceiling in the common bathroom with a light bulb exposed and turned on.</li> </ul>	D 076		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 076	<p>Continued From page 6</p> <p>Observation on 12/11/14 at 10:10 am revealed: -7 of 9 fabric-covered chairs in the resident dining room revealed black, brown, and tan stains spattered three to four inches on the front of the seat cushions. -2 of 9 fabric-covered chairs also had black spotted stains that were spattered for four inches up the back cushions of the chairs.</p> <p>Interview with two residents in bedroom #3 on 12/11/14 at 10:55 am revealed: -A resident stated his dresser had been broken since he arrived at the facility three weeks ago and he had a difficult time getting his clothes in and out of the dresser. -A resident stated he had spoken to facility staff about his broken dresser, but nothing was done.</p> <p>Interview with two residents in bedroom #4 on 12/11/14 at 10:20 am revealed: -The drawers of the dressers had been "like that" for a while. -They could use the chest of drawers in the condition as they were.</p> <p>Interview with the Administrator on 12/11/14 at 11:50 am revealed: -She was not aware that the drawers on the dressers were difficult to open and close. -The storage cabinet in the bathroom "was here from the previous owners and needs to be taken out to the trash since it has rust on it". -She was not aware of the light fixture that needed repair. -The company that owned the building purchased it in July 2014 and the furniture was obtained in the purchase. -The company had limited money to spend for repairs. -She would make the owner aware of the need</p>	D 076		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 076	Continued From page 7 for the dressers to be repaired and she would obtain a replacement for the storage cabinet in the bathroom.	D 076		
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 interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) according to G.S. 131E-256.  The findings are:  Review of Staff B's personnel records revealed: -No documented date of hire. -No documentation of a HCPR check.  Review of Medication Administration Records revealed Staff B worked at the facility on 12/02/14 and 12/11/14.  Interviews on 12/11/14 at 2:45 pm and 12/12/14 at 9:13 am with Staff B revealed: -She had been employed at a sister facility for about two years. -She was permanently transferring to this facility as soon as the Administrator hired a replacement for her at the sister facility.	D 137	<b>The Administrator will ensure all staff have no substantiated findings listed on the North Carolina Health Care Personnel</b>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 137	<p>Continued From page 8</p> <p>-She did not know anything about HCPR checks.</p> <p>Interview on 12/11/14 at 1:15 pm with the Administrator revealed:</p> <p>-Staff B was employed at a sister facility and had a HCPR check done upon hire at the sister facility in 2013.</p> <p>-Staff B was in the process of transferring to this facility full time but was waiting for the Administrator to hire her replacement at the sister facility.</p> <p>-Staff B's official hire date for this facility would be the first day she worked at the facility, which was 12/02/14.</p> <p>-Prior to beginning the transfer of Staff B to this facility, the Administrator contacted the county Department of Social Services (DSS) to ask if the HCPR check had to be completed for Staff B at this facility.</p> <p>-The Administrator was informed by DSS that the HCPR check was not required to be completed at every facility when there were multiple facilities under the same ownership.</p> <p>-Since Staff B was an existing employee at a sister facility and the HCPR check was completed upon hire at the sister facility, it did not need to be completed again upon transfer to this facility.</p> <p>-The Administrator would have completed a HCPR if she had known it was required.</p> <p>Interview on 12/11/14 at 1:30 pm with the county Adult Home Specialist (AHS) revealed:</p> <p>-She recently sent an email to her facilities notifying them that HCPR checks did not need to be done at each individual facility when there were multiple facilities under the same ownership.</p> <p>-The email was intended to refer to newly hired staff who would be working at multiple facilities under the same ownership.</p> <p>-The instruction was not meant to include</p>	D 137	<p><b>Registry. Administrator will ensure everyone has documented date of hire and documentation of a HCPR check.</b></p> <p><b>Administrator will check all staff records and ensure areas are in compliance. Administrator will check records monthly. Administrator will ensure this is completed prior to staff working at facility. All records will be checked by 1/26/15 and monthly thereafter.</b></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 137	Continued From page 9 employees transferring to newly acquired facilities.  Review of Staff B's personnel records from the sister facility revealed a HCPR check was completed on 07/29/13 with no substantiated findings.  Review of a HCPR check completed on 12/12/14 for Staff B revealed no substantiated findings.  Interviews with 3 sampled residents revealed they had no complaints or concerns with care or services provided by Staff B.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications  10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40;  This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had a criminal background check in accordance with G.S. 114-19.10 and 131D-40.  The findings are:  Review of Staff B's personnel records revealed: -No documented date of hire. -No documentation of a criminal background check.  Review of Medication Administration Records revealed Staff B worked at the facility on 12/02/14 and 12/11/14.	D 139	<b>The Administrator will ensure all Staff have a criminal background check in accordance G.S. 114-19 and 131D-40. All staff records will be checked to ensure compliance in this rule area and corrected immediately. Administrator will ensure this is completed prior to staff working at the facility. All records will be checked by 1/26/15 and monthly thereafter.</b>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 139	<p>Continued From page 10</p> <p>Interviews on 12/11/14 at 2:45 pm and 12/12/14 at 9:13 am with Staff B revealed:</p> <ul style="list-style-type: none"> <li>-She had been employed at a sister facility for about two years.</li> <li>-She was permanently transferring to this facility as soon as the Administrator hired a replacement for her at the sister facility.</li> <li>-She had a criminal background check completed at the sister facility but had not been had one completed at this facility.</li> <li>-She did not know the criminal background check needed to be completed again for transfer to this facility.</li> </ul> <p>Interview on 12/11/14 at 1:15 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-Staff B was employed at a sister facility and had a criminal background check done upon hire at the sister facility.</li> <li>-Staff B was in the process of transferring to this facility full time but was waiting for the Administrator to hire her replacement at the sister facility.</li> <li>-Staff B's official hire date for this facility would be the first day she worked at the facility, which was 12/02/14.</li> <li>-Prior to beginning the transfer of Staff B to this facility, the Administrator contacted the county Department of Social Services (DSS) to ask if the criminal background check had to be completed for Staff B at this facility.</li> <li>-The Administrator was informed by DSS that the criminal background check was not required to be completed at every facility when there were multiple facilities under the same ownership.</li> <li>-Since Staff B was an existing employee at a sister facility and the criminal background check was completed upon hire at the sister facility, it did not need to be completed again upon transfer</li> </ul>	D 139		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 139	Continued From page 11 to this facility. -The Administrator would have obtained a criminal background check if she had known it was required.  Interview on 12/11/14 at 1:30 pm with the county Adult Home Specialist (AHS) revealed: -She sent an email to her facilities notifying them that criminal background checks did not need to be done at each individual facility when there were multiple facilities under the same ownership. -The email was intended to refer to newly hired staff who would be working at multiple facilities under the same ownership. -The instruction was not meant to include employees transferring to newly acquired facilities.  Review of Staff B's personnel records from the sister facility revealed a criminal background check was completed on 07/31/13.  Interviews with 3 sampled residents revealed they had no complaints or concerns with care or services provided by Staff B.	D 139		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunization  10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (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,	D 234	The Administrator will ensure residents upon admission shall be tested for tuberculosis disease in compliance with the control measures by the commission for health services and specified in 10A NCAC 41A .0205. The Administrator will review all residents' charts to ensure areas are in compliance. Monthly reviews will be completed on all residents charts. All charts will be checked and corrected by 1/26/15 and monthly thereafter.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 234	<p>Continued From page 12</p> <p>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 1 of 3 sampled residents (Resident #2) had documentation upon admission for testing of tuberculosis (TB) disease or had documentation of a history of positive TB testing and a Record of Screening for TB disease in compliance with the control measures adopted by the Commission for Health Services.</p> <p>The findings are:</p> <p>Review of Resident #2's FL-2 dated 7/23/14 revealed a diagnosis of abdominal aortic aneurysm, arteriosclerotic dementia, cerebrovascular accident, and hypertension.</p> <p>Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 07/11/2008.</p> <p>Review of Resident #2's record revealed: -No documentation of TB testing. -A written recommendation on the LHPS assessment on 08/11/14 for a chest x-ray be done (TB screen). -No documentation of results of a TB symptom screen or a chest x-ray.</p> <p>Interview on 12/11/14 at 5:00 pm with a nurse revealed: -She was responsible for the LHPS assessments. -On 08/11/14, she assessed Resident #2, who was new to her since the company had just purchased the building in July 2014. -She reviewed his previous record which included documentation he had had a previous positive</p>	D 234		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  HAL050129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  12/12/2014
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  RADBOURNE MANOR III	STREET ADDRESS, CITY, STATE, ZIP CODE 2920 CINDY LANE CHARLOTTE, NC 28269
---	---

(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
D 234	<p>Continued From page 13</p> <p>PPD skin test. -Her procedure was to do a TB symptom screening assessment annually when a resident had a previous positive PPD skin test. -She did a TB symptom screening assessment on 08/11/14, which she gave to a previous SIC to file, and recommended that the facility ask the physician for an order for a chest x-ray. -She was not sure why the previous TB screens and her TB screening assessment was not in Resident #2's record.</p> <p>Interview on 12/11/14 at 4:30 pm with the Administrator revealed: -She was not aware that Resident #2's TB skin test from his admission on 07/11/2008 was not in the record. -She was sure he had one on file "because his record has been reviewed several times." -The facility had been bought in July 2014 and the previous owner "had taken some boxes of records".</p> <p>Further interview on 12/12/14 at 1:15 pm with the Administrator revealed: -She had contacted the previous owner to request they see if they have the TB screen information for Resident #2. -She was having the nurse do a PPD skin test on Resident #2 today. -She had contacted Resident #2's physician and the health department to see if they had a record of a previous PPD test, which they did not.</p> <p>No TB testing was provided by the facility for Resident #2 by the end of the survey.</p>	D 234		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 273	<p>Continued From page 14</p> <p>10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: <b>TYPE B VIOLATION</b></p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health care needs of 2 of 3 sampled residents (Resident #2 and #3) regarding physician notification of fingerstick blood sugar (FSBS) results and recommendations from the Licensed Health Professional Support nurse.</p> <p>The findings are:</p> <p>A. Review of Resident #3's current FL-2 dated 08/26/14 revealed: -Diagnoses included diabetes mellitus type II, schizophrenia, and mild mental retardation. -An order for FSBS testing 3 times daily before meals. -No ordered parameters for physician notification of FSBS results.</p> <p>Observation on 12/11/14 at 11:46 am revealed: -Staff B, medication aide, performed FSBS testing for Resident #3. -The FSBS result was 417. -Staff B was not observed to notify the physician of the FSBS result.</p> <p>Observation on 12/11/14 at 4:31 pm revealed: -Staff A, medication aide, performed FSBS testing for Resident #3.</p>	D 273	<p>The Administrator will ensure referral and follow-up to meet the routine and acute health care needs of residents are met. The Administrator and designee will ensure the facility referral and follow up to meet the routine and acute health care needs regarding physician notification of finger stick blood sugar results and recommendations from the Licensed Health Professional Support nurse.</p> <p>All resident records with FSBS were checked. The residents MD was notified and a facility policy is in place to notify residents doctor if blood sugars exceeds the specific range. Although facility can not make a resident MD provide ranges for notification, a facility procedure is in place. All identified issues were addressed and followed up immediately. Documentation will be maintained in resident's charts for review. Administrator will monitor weekly. All med techs will be in-serviced by 1/26/15 to ensure current system are being followed and maintained. A policy is in place regarding hypoglycemia and hyperglycemia and readily available. Administrator and or designee will continue to monitor weekly. All areas corrected by 1/26/15.</p> <p>Administrator also audited all residents record to ensure referral and followup are met for the routine and acute health care needs of residents.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 273	<p>Continued From page 15</p> <p>-The FSBS result was 594. -Staff A was not observed to contact the physician.</p> <p>Review of October 2014 Blood Glucose Record revealed: -FSBS testing was scheduled three times daily at 7:30 am, 11:30 am, and 4:30 pm. -FSBSs ranged from 216 to 519 with one result of "H". (The American Diabetes Association recommends blood sugars be kept between 90 and 130. -There was no documentation the physician was notified of FSBS results.</p> <p>Review of November 2014 Blood Glucose Record revealed: -FSBS testing was scheduled three times daily at 7:30 am, 11:30 am, and 4:30 pm. -FSBSs ranged from 203 to 591 with one result of "H". -There was no documentation the physician was notified of the FSBS results.</p> <p>Review of December 2014 Blood Glucose Record revealed: -FSBS testing was scheduled three times daily at 7:30 am, 11:30 am, and 4:30 pm. -FSBSs ranged from 288 to 594. -There was no documentation the physician was notified of the FSBS results.</p> <p>Review of Resident #3's record revealed: -There was no documentation the physician was notified of any of the FSBS results. -There was documentation of one visit to the resident's medical doctor since admission in August 2014. -The resident was seen on 12/02/14 for "followup" and "diabetes", at which time the physician</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 273	<p>Continued From page 16</p> <p>increased the resident's current insulin orders.</p> <p>Interview on 12/12/14 at 9:13 am with Staff B revealed:</p> <ul style="list-style-type: none"> <li>-She was "not sure" what would be considered too high or too low for FSBS readings.</li> <li>-"If it's like 500, I'd ask how they're feeling".</li> <li>-Staff B stated she would call the Administrator for direction if the resident was feeling bad.</li> <li>-Staff B confirmed she did not notify the physician regarding FSBS results.</li> </ul> <p>Interview on 12/12/14 at 10:40 am with Staff A revealed:</p> <ul style="list-style-type: none"> <li>-She had worked at the facility since July 2014.</li> <li>-She considered FSBS of 500 and 600 to be too high and she would notify the physician.</li> <li>-Staff A did not know why she did not notify the physician of the FSBS of 594 the previous day.</li> <li>-Staff A stated she attempted to notify the physician on one occasion of a high FSBS result but did not get a call back from the physician's office, so she left a message for the next shift to follow up.</li> <li>-Staff A stated she did not know why she did not routinely notify the physician of high FSBS results.</li> </ul> <p>Interview on 12/12/14 at 8:45 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-She had been the Administrator of the facility since July 2014 when the company she worked for acquired the facility.</li> <li>-She had worked for the company for "almost a year".</li> <li>-She did not know what the facility policy was regarding physician notification of abnormal FSBS results.</li> <li>-She was unable to locate a facility policy regarding hypoglycemia and hyperglycemia.</li> </ul>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 273	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-She did not know whether or not the physician had ordered parameters for notification.</li> <li>-When the resident was seen in the doctor's office, a copy of his MAR and FSBS results were sent with him for the physician to review.</li> <li>-She reviewed each resident's record and MAR "about twice a month" looking for holes in the documentation, medications circled as not administered, and accurate transcription of orders.</li> <li>-During her review of Resident #3's record and MARs, she did not observe high FSBS readings that would have prompted a call to the doctor or she would have called him or instructed staff to call.</li> </ul> <p>Telephone interview on 12/12/14 at 5:12 pm with Resident #3's physician revealed:</p> <ul style="list-style-type: none"> <li>-He recently increased Resident #3's insulin in an attempt to manage his high FSBSs.</li> <li>-He had not ordered parameters for notification of FSBS results, but would expect the facility to notify him if a FSBS was below 60 or above 400.</li> </ul> <p>Interview on 12/12/14 at 2:20 pm with Resident #3 revealed:</p> <ul style="list-style-type: none"> <li>-He relied on the facility staff to perform his FSBS monitoring.</li> <li>-Staff checked his FSBS four times daily and administered insulin three times daily.</li> <li>-He was not able to tell if his FSBS was too high or too low, he always felt "normal".</li> </ul> <p>B. Review of Resident #2's FI-2 dated 7/23/14 revealed a diagnosis of abdominal aortic aneurysm, arteriosclerotic dementia, cerebrovascular accident, and hypertension.</p> <p>Review of Resident #2's Resident Register revealed the resident was admitted to the facility</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 273	<p>Continued From page 18 on 07/11/2008.</p> <p>Review of Resident #2's record on 12/11/14 revealed: -A written recommendation on the LHPS assessment on 08/11/14 for a chest x-ray (TB screen). -No order for or results of a chest x-ray were in the record.</p> <p>Interview on 12/11/14 at 5:00 pm with a nurse revealed: -She was responsible for the LHPS assessments. -On 08/11/14, she assessed Resident #2, who was new to her since the company had just purchased the building in July 2014. -She reviewed his previous record which included documentation that he had had a previous positive PPD skin test. -On 08/11/14, she recommended that Resident #2 have a chest x-ray based on the previous PPD skin test. -She saw the resident for re-assessment on 11/19/14, but did not realize that the facility had not contacted Resident #2's physician with a request for a chest x-ray. -The Supervisor in Charge was the person that she made aware of her recommendations, but the SIC that was in charge on 08/11/14 and 11/19/14 was no longer employed at the facility.</p> <p>Interview on 12/12/14 at 1:15 pm with the Administrator revealed: -"I don't do anything with LHPS. The SIC handles this." -The facility had not had a person in the SIC role since November 28, 2014. -She was in the process of training a new person for the SIC role. -She was not aware that Resident #5 had</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 273	<p>Continued From page 19</p> <p>previously had a positive TB skin test.</p> <p>-She was not aware of the recommendation from the LHPS on 08/11/14 that a chest x-ray was needed for Resident #5.</p> <p>-She was not aware that the physician had not been contacted to request an order for a chest x-ray for Resident #5.</p> <p>On 12/12/14, the Administrator submitted a Plan of Protection as follows:</p> <p>-The Administrator or assigned SIC would immediately review resident records to identify any health care issues requiring referral or follow up.</p> <p>-All identified issues would be followed up immediately.</p> <p>-The Administrator or assigned SIC would audit records monthly to identify any health care issues requiring follow up.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 26, 2015.</p>	D 273		
D 290	<p>10A NCAC 13F .0904(c)(1) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements in Paragraph (d) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility</p>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
--------------------	--	---------------	---	--------------------

D 290	<p>Continued From page 20</p> <p>failed to assure menus were available for guidance of food service staff with serving quantities specified for regular and therapeutic diets.</p> <p>The findings are:</p> <p>Observation on 12/11/14 at 12:15 pm of the kitchen revealed: -A posted menu for regular and therapeutic diets for Fall/Winter Lunch Week Four.</p> <p>Review of the posted menu for lunch for 12/11/14 revealed: -Diets listed were Regular, Mechanical Soft, No-Added Salt, and Balanced Carb. -No serving quantities, sizes, or measurements for food or beverages were specified on the menu. -All residents were to be served breaded pork outlet, sweet potatoes, broccoli, roll or bread, and beverage of choice. -All residents, except those on a Balanced Carbohydrate diet were to be served frosted cake. -Residents on a Balanced Carbohydrate diet were to be served cake without frosting. -The menu specified if a resident on a Balanced Carb diet received no cake, he/she could have 2 rolls.</p> <p>Observation of plate preparation and serving of residents at lunch on 12/11/14 at 12:30 pm revealed: -Six male residents were served in the dining room. -All residents were served one pork loin (approximately 6 ounces), broccoli (approximately 6 ounces), sweet potatoes (approximately 6 ounces), and a roll.</p>	D 290	<p>The Administrator will ensure Menus are available for guidance of food service staff with servicing quantities specified for regular and therapeutic diets. Administrator will ensure dietician revised menus to reflect food portions for staff reference and guidance for service. Administrator will ensure all cooks/staff are trained and understand measurements are required for food portions. Administrator will ensure training and menus are available by 2/15/15, Administrator or designee will monitor weekly to ensure compliance.</p> <p><u>****Administrator questioned Survey Team leader, since menus have not changed since last 2 STATE surveys. Previous owner used the same menus for the past 2 years and this area was not a problem using the exact same MENUS — Same Team Leader was apart of the previous surveys.</u></p>	
-------	---	-------	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL080129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 290	<p>Continued From page 21</p> <ul style="list-style-type: none"> <li>-Staff B, who was plating, used a large slotted spoon for the vegetables and utilized no measuring tools.</li> <li>-Pudding or jello was offered to two residents for dessert.</li> <li>-Four residents had left the dining room prior to dessert being offered.</li> <li>-Water (10 ounces) and beverage of choice (10 ounces) was served to all residents.</li> </ul> <p>Interviews with residents during the initial tour on 12/11/14 from 10:15 am to 11:00 am revealed that they received snacks three times a day and were provided three meals a day with no complaints as to the quantity of food provided.</p> <p>Interview on 12/11/14 at 12:40 pm with Staff B, Nurse Aide (NA), revealed:</p> <ul style="list-style-type: none"> <li>-She had worked at the facility for two days and was "learning the residents".</li> <li>-She worked first shift and was responsible for meal and snack preparations.</li> <li>-She prepared and served the food according to what was listed on the posted menu for the regular and therapeutic diets for that meal.</li> </ul> <p>Further interview on 12/12/14 at 12:20 pm with Staff B, NA, revealed:</p> <p>"I don't know how much to put on the plate because there aren't any measurements on the menu."</p> <ul style="list-style-type: none"> <li>-"For the vegetables, I usually give them one spoonful using this spoon" (She demonstrated with a large slotted spoon used in food preparation).</li> <li>-"This morning I did not know how much oatmeal to give them, so I just gave them 2 ½ spoons of oatmeal using a large serving spoon."</li> <li>-"They can always ask for second helpings."</li> <li>-She had not had training at the time of her</li> </ul>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 290	<p>Continued From page 22</p> <p>employment at the facility and prior to preparing meals for the residents of the facility.</p> <p>Interview on 12/12/14 at 1:05 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-A registered dietician wrote the menus for diets currently being used and posted in the kitchen for staff reference.</li> <li>-She was aware there were no measurements for food portions.</li> <li>-She and the Supervisor in Charge (SIC) were responsible for training new staff regarding meal preparation.</li> <li>-The facility currently did not have an SIC at the present time.</li> <li>-She would contact the dietician and request menus with food portions for staff reference and guidance for serving.</li> </ul>	D 290		
D 310	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure therapeutic diets were served as ordered by the physician for 1 of 3 sampled residents (Resident #4).</p> <p>The findings are:</p> <p>Review of Resident #4's current FI-2 dated</p>	D 310	<p>Administrator will ensure facility therapeutic diets, including nutritional supplements and thickened liquids are serviced as ordered by residents physician. Administrator will audit all residents' diets to ensure diets are followed. All identified areas will be corrected immediately. Will have area in compliance by <u>2/15/15</u> and monitored by Administrator or designee weekly.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 310	<p>Continued From page 23</p> <p>07/24/14 revealed: -Diagnosis of hypotension and congestive heart failure -An order for a regular diet.</p> <p>Review of Resident #4's record revealed a subsequent diet order signed by the physician dated 9/26/14 for a "low carbohydrate diet - breakfast one serving, lunch fruit and vegetables only, dinner one serving, and no snacks."</p> <p>Review of the diet menu posted in the kitchen revealed a "balanced carb", but no menu for a low carbohydrate diet.</p> <p>Review of the diet board on 12/11/14 at 12:15 pm posted in the kitchen near the serving station revealed Resident #4 was to be served a regular diet as well as instructions under "likes and dislikes" for Resident #4 to have breakfast one serving, lunch fruit and vegetables only, dinner one serving, and no snacks.</p> <p>Observation of the lunch meal served to Resident #4 on 12/11/14 at 12:25 pm revealed: - Resident #4 was served one breaded pork cutlet, sweet potatoes (approximately 6 ounces), broccoli (approximately 6 ounces), and a sugar-free pudding. -The resident ate 100% of the meal served from the dietary staff. -Another resident offered Resident #4 his sweet potatoes, which Resident #4 accepted and ate (approximately 4 ounces). -There was no staff in the dining room at the time that Resident #4 accepted the additional sweet potatoes.</p> <p>Interview on 12/11/14 at 12:40 pm with Staff B, Nurse Aide (NA), revealed:</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 310	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>-She had worked at the facility for two days and was "learning the residents".</li> <li>-She worked first shift and was responsible for meal and snack preparations.</li> <li>-She was aware there were residents on therapeutic diets, specifically balanced carbohydrates, "but they all get the same thing today on the menu."</li> <li>-She was not aware, and had not received orientation to the use of the diet board posted with each resident's diet orders.</li> </ul> <p>Interview on 12/12/14 at 12:30 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> <li>-He had recently been to the doctor because of high blood pressure and "my doctor told me to just have fruits and vegetables for lunch and no meats at lunch."</li> <li>-His doctor had told him he needed to lose weight</li> <li>-"I had pork yesterday. It is up to whoever is fixing my plate to just give me fruits and vegetables."</li> <li>-"The doctor told me one serving is enough and I can't have seconds."</li> </ul> <p>Further interview on 12/12/14 at 12:20 pm with Staff B revealed she was unaware on 12/11/14 when serving lunch that Resident #4 was to only have fruit and vegetables and not meat.</p> <p>Interview on 12/12/14 at 1:10 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-The "menu for the diets" posted in the kitchen was developed by a registered dietician.</li> <li>-She provided a letter, with no date, stating that a licensed Registered Dietician in the state of North Carolina had prepared menus in accordance with guidelines set for by the state of NC for the previous owner's of the facility.</li> </ul>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL050129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 310	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>-She was unaware that Resident #4's diet was posted as a regular diet on the diet board in the kitchen.</li> <li>-The facility offered a balanced carbohydrate diet, not a low carbohydrate diet.</li> <li>-She had informed Resident #4's physician at the time he wrote the order on 9/26/14 for the low carbohydrate diet that the facility only offered a balanced carbohydrate diet and he said "they are the same".</li> <li>-She had not received an order for a Balanced Carbohydrate diet for Resident #4 as of 12/12/14.</li> <li>-Resident #4 was being served a Balanced Carbohydrate diet "because the doctor said it is the same as a Low Carbohydrate diet".</li> <li>-To her knowledge, the facility not have a therapeutic diet spread sheet with specific portion sizes for staff reference.</li> <li>-Staff B had only worked 3 days at this facility.</li> <li>-Staff B worked as a NA/cook at another facility owned by the company.</li> <li>-Staff B had not received formal training regarding preparing resident's therapeutic diets prior to preparing meals for this facility's residents.</li> <li>-The SIC position was responsible for providing dietary staff with initial and subsequent diet orders for residents; however, this position had been vacant since 11/28/14.</li> <li>-"No one has been updating the diet board since the SIC has been vacant".</li> </ul>	D 310		
D 317	<p>10A NCAC 13F .0905 (d) Activities Program</p> <p>10A NCAC 13F .0905 Activities Program</p> <p>(d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization,</p>	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL068129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 317	<p>Continued From page 26</p> <p>physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure at least 14 hours of planned group activities were provided each week that promoted socialization and physical interaction for the 10 residents per census residing in the facility.</p> <p>The findings are:</p> <p>Observations on 12/11/14 at 11:00 am of the December 2014 activity calendar revealed:</p> <ul style="list-style-type: none"> <li>- 14 hours of scheduled activities during each week of December 2014.</li> <li>- 3 hours out of the 14 hours each week were watching a movie.</li> <li>- 2 hours out of the 14 hours each week were visiting a local church</li> <li>- 2 hours out of the 14 hours each week were bible study.</li> <li>- The remainder of the 14 hours included bingo, nature walks, and arts and crafts.</li> </ul> <p>Interview with one resident revealed:</p> <ul style="list-style-type: none"> <li>- The resident stated, "There are no activities at the facility."</li> </ul>	D 317	<p>The Administrator or designee will ensure at least 14 hours of planned group activities are provided each week that promotes socialization and physical interaction for all residents in the facility.</p> <p>The Administrator or designee will encourage all residents to participated and document Accordingly.</p> <p>Activity items were purchased and stored in the front closet. Detail documentation will be kept and available for review. Administrator will have meeting with residents by 1/26/15, and meet monthly to encourage participation.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL050129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  
**RADBOURNE MANOR III**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2920 CINDY LANE  
CHARLOTTE, NC 28269**

(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
D 317	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>- The only activities done by residents is playing bingo at a local church and watching television.</li> <li>- The resident stated that the facility never takes him on outing in the community.</li> <li>- The resident stated he has never participated in any arts and crafts activities at the facility.</li> <li>- The resident stated there is a checkerboard game but many of the pieces are missing.</li> <li>- The resident stated that the facility he just moved from had activities for residents.</li> </ul> <p>Interviews with two additional residents revealed:</p> <ul style="list-style-type: none"> <li>-A resident stated "there is nothing to do at the facility."</li> <li>-A resident stated that watching television is the only activity done by residents.</li> <li>-A resident stated that the last facility he lived at always had activities for residents.</li> <li>- A resident stated he does not like the facility because of the lack of activities.</li> <li>- A resident stated that he has lived at the facility for five years, and has never seen any activities done with residents.</li> </ul> <p>Interview with a fourth resident revealed:</p> <ul style="list-style-type: none"> <li>-The facility does not have activities for the residents.</li> <li>- "All I want to do is lay down and watch TV. "</li> <li>-The resident did not know who was responsible for activities for the facility.</li> </ul> <p>Interview with Staff B on 12/11/14 at 2:25 pm revealed:</p> <ul style="list-style-type: none"> <li>- Staff B has only worked at the facility for two days.</li> <li>- Staff B is scheduled to work on 1st shift.</li> <li>- The only activities Staff B has observed residents doing is watching television.</li> <li>- Staff B has never facilitated any activities for the residents.</li> </ul>	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D 317	<p>Continued From page 28</p> <ul style="list-style-type: none"> <li>- Staff B has never observed any other staff members facilitating any activities.</li> <li>- Staff B is aware that the activities calendar is located outside of the staff office.</li> <li>- Staff B is unaware of who is responsible for completing the activities calendar.</li> <li>- Staff B has never heard residents complaining about not having anything to do.</li> </ul> <p>Interview with Administrator on 12/11/14 at 2:34 pm revealed:</p> <ul style="list-style-type: none"> <li>- Administrator stated the facility does not have an Activity Director.</li> <li>- Administrator stated that she was aware that the facility had to have an Activity Director.</li> <li>- Administrator stated she is responsible for completing the monthly activities calendar.</li> <li>- Administrator stated staff are responsible for facilitating the activities on the calendar.</li> <li>- Administrator stated that a current staff member will be hired as the Activity Director.</li> <li>- Administrator stated that facility has the appropriate supplies to complete activities.</li> </ul> <p>Observation of facility supply closet on 12/11/14 at 2:51 pm revealed no activity supplies.</p> <p>Interview with a resident's family member revealed:</p> <ul style="list-style-type: none"> <li>- Family member stated the resident has been living at the facility for three or four months.</li> <li>- Family member stated she visits the facility monthly.</li> <li>- Family member stated her last visit to facility was on Thanksgiving Day.</li> <li>- Family member stated the resident appears to be in good spirits when visited.</li> <li>- Family member stated that her major complaint with the facility is their lack of activities.</li> <li>- Family member stated she has never seen any</li> </ul>	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  
**RADBOURNE MANOR III**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**2920 CINDY LANE  
CHARLOTTE, NC 28269**

(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
D 317	Continued From page 29 activities done at the facility. -Family member stated that she is also frustrated that the facility never provides transportation for activities outside of the facility (ex: shopping).	D 317		
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 ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding tuberculosis testing, Licensed Health Professional Support recommendations, and physician notification of fingerstick blood sugar results.</p> <p>The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health care needs of 2 of 3 sampled residents (Resident #2 and #3) regarding physician notification of fingerstick blood sugar (FSBS) results and recommendations from the Licensed Health Professional Support nurse. [Refer to Tag 273, 10A NCAC 13F .0902(b) (Type B Violation).]</p>	D912	<p><b>The Administrator will ensure residents receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding tuberculosis testing, Licensed Health Professional Support recommendations and physician notification of fingerstick blood sugar results.</b></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D992	Continued From page 30	D992		
D992	<p>G.S. § 131D-45 Examination and screening</p> <p>G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.</p> <p>(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 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:</p>	D992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>
--	---

(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
D992	<p>Continued From page 31</p> <p>Based on interviews and record reviews, the facility failed to complete an examination and screening for the presence of controlled substances for 1 of 3 staff (Staff B) prior to hire.</p> <p>The findings are:</p> <p>Review of Staff B's personnel records revealed: -No documented date of hire. -No documentation of screening for controlled substances.</p> <p>Review of Medication Administration Records revealed Staff B worked at the facility on 12/02/14 and 12/11/14.</p> <p>Interviews on 12/11/14 at 2:45 pm and 12/12/14 at 9:13 am with Staff B revealed: -She had been employed at a sister facility for about two years. -She was permanently transferring to this facility as soon as the Administrator hired a replacement for her at the sister facility. -She was drug tested at the sister facility but had not been tested at this facility. -She did not know the drug testing needed to be completed again for transfer to this facility.</p> <p>Interview on 12/11/14 at 1:15 pm with the Administrator revealed: -Staff B was employed at a sister facility and had drug testing completed at the sister facility. -Staff B was in the process of transferring to this facility full time but was waiting for the Administrator to hire her replacement at the sister facility. -Staff B's official hire date for this facility would be the first day she worked at the facility, which was 12/02/14. -Prior to beginning the transfer of Staff B to this</p>	D992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>RADBOURNE MANOR III</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2920 CINDY LANE CHARLOTTE, NC 28269</b>		
(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
D992	<p>Continued From page 32</p> <p>facility, the Administrator contacted the county Department of Social Services (DSS) to ask if the drug testing had to be completed for Staff B at this facility.</p> <p>-The Administrator was informed by DSS that the screening for controlled substances was not required to be completed at every facility when there were multiple facilities under the same ownership.</p> <p>-Since Staff B was an existing employee at a sister facility and the drug testing was completed at the sister facility, it did not need to be completed again upon transfer to this facility.</p> <p>-The Administrator would have obtained a screening for controlled substances if she had known it was required.</p> <p>Interview on 12/11/14 at 1:30 pm with the county Adult Home Specialist (AHS) revealed:</p> <p>-She sent an email to her facilities notifying them that screening for controlled substances did not need to be done at each individual facility when there were multiple facilities under the same ownership.</p> <p>-The email was intended to refer to newly hired staff who would be working at multiple facilities under the same ownership.</p> <p>-The instruction was not meant to include employees transferring to newly acquired facilities.</p> <p>Review of Staff B's personnel records from the sister facility revealed a screening for controlled substances was completed on 10/24/13.</p> <p>Interviews with 3 sampled residents revealed they had no complaints or concerns with care or services provided by Staff B.</p>	D992		

## Shook, Linda

---

**From:** Moore, Bonnie  
**Sent:** Friday, February 13, 2015 7:19 AM  
**To:** 'nina.anderson@mecklenburgcountync.gov'  
**Cc:** Shook, Linda  
**Subject:** Radbourne Manor III POC  
**Attachments:** Radbourne Manor III 2014-12-12 POC EAJI11.pdf

Please find attached to this email the approved Plan of Correction for Radbourne Manor III, HAL-060-129, Forsyth County.  
Thank you,

Bonnie Moore, RN  
N.C. Department of Health and Human Services  
Facility Survey Consultant - Division of Health Service Regulation  
Adult Care Licensure Section  
12 Barbetta Drive  
Asheville, NC 28806  
Phone: 336-341-8130  
Fax: 828-260-5040  
[Bonnie.moore@dhhs.nc.gov](mailto:Bonnie.moore@dhhs.nc.gov)  
[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr)

Email correspondence to and from this address is subject to the North Carolina Public Records Law and may be disclosed to third parties by an authorized State official. Unauthorized disclosure of juvenile, health, legally privileged, or otherwise confidential information, including confidential information relating to an ongoing State procurement effort, is prohibited by law. If you have received this e-mail in error, please notify the sender immediately and delete all records of this e-mail.