

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  
**POOLE'S REST HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**201 MARY JANE BIGELOW ROAD  
YANCEYVILLE, NC 27379**

(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 Caswell County Department of Social Services conducted an annual and follow-up survey on November 12, 2014.	D 000		
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, interview and record review, the facility failed to assure 8 of 17 dining room chairs and 3 of 4 dining tables (A, B, D) and living room furniture were clean and in good repair. The findings are:  Observation on 11/12/14 at 10 a.m. of the living room on entrance to the facility revealed: - A large sofa had with a 1 - 1 1/2 foot round area on the arm of the sofa covered with a silver colored industrial repair tape. - A desk chair had slits in the vinyl seating cover with the stuffing exposed. - A small love seat had areas of stuffing from the seat hanging out. - A cloth with a stringy raw edge had been placed over the seat of the love seat.  On 11/12/14 at 10 a.m. upon entrance to the facility, resident interviews revealed: - Residents had noticed the problem with the furniture for "years". - One resident said all of the furniture in the living	<u>D 076</u>	Completed - new sofas + chairs were purchased.    1/30/15 TC. Addendum Adminstrator D 076 Plan to purchase new replacement furniture. The Administrator will review all furniture in the facility on a weekly basis to ensure furniture is clean & in good repair. Kmelis	12/3/14  DOC KML

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

TITLE

(X6) DATE

1/30/15 Addendum obtained. Provider has not signed this form Kmelis  
POC approved but →

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 1</p> <p>room and dining room could be cleaned or replaced.</p> <p>Interview on 11/12/14 at 10:10 a.m. with the facility cook revealed:</p> <ul style="list-style-type: none"> <li>- Dining tables and chairs were cleaned daily but had not been cleaned today as yet.</li> <li>- She had tried to clean the dining chair stains many times but they would not come completely clean.</li> <li>- The reddish brown substance on the table edges placed at intervals was an insecticide placed by the exterminator.</li> <li>- There was no deep cleaning schedule as such, but when the dining room walls were deep cleaned every so often as needed.</li> </ul> <p>During the facility tour of the Dining Room on 11/12/14 at 10:20 a.m. revealed 3 of the 4 dining tables were not clean as follows:</p> <ul style="list-style-type: none"> <li>- Dining Room Table A was sticky to touch.</li> <li>- Table B had dried liquid spills and sticky areas.</li> <li>- Table D had reddish brown thick substance smeared along the table edges and legs.</li> <li>- Table D's laminated top on was separated on one corner and was raised up 1- 2 inches.</li> </ul> <p>During the facility tour of the Dining Room on 11/12/14 at 10:20 a.m. revealed 8 of 16 dining chairs were not clean as follows:</p> <ul style="list-style-type: none"> <li>- The 3 white chairs at Table A had black, brownish smears along the top of the back of the chairs</li> <li>- The base of the 3 white chairs at Table A had legs that were sticky with food.</li> <li>- One of these white chairs wobbled to touch and was not stable.</li> <li>- Table B had 4 chairs and one white chair had food stains along the top of the chair back.</li> <li>- A brown chair at Table B had thick black sticky</li> </ul>	D 076	<p>Completed- new tables and chairs have purchased to replace the old ones.</p>	12/3/14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 2.</p> <p>grimy substance all along the top of the chair back.</p> <ul style="list-style-type: none"> <li>- Three brown chairs at Table D had grimy thick black sticky substance along the top of the chair back.</li> </ul> <p>Recheck of dining chairs and table on 11/12/14 at 2:30 p.m. revealed tables and chairs had not been cleaned.</p> <p>Interview on 11/12/14 at 10:40 a.m. with a resident revealed:</p> <ul style="list-style-type: none"> <li>- The dining room chairs and tables had been the the current condition for years.</li> <li>- The furnityre in the living room had been in the current condition for about 2 years.</li> <li>- Residents would like to see the furniture in good condition.</li> </ul> <p>Interview on 11/12/14 at 5:10 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>- She knew about the condition of the dining chairs but was not aware of the condition of the dining tables.</li> <li>- There was no deep cleaning schedule but the furniture in the dining room was cleaned daily.</li> <li>- The dining chairs had been cleaned so many times.</li> <li>- The chairs would not come clean.</li> <li>- The administrator said she thought she would have to throw the chairs out and get new ones.</li> </ul> <p>Review of the sanitation report dated 6/30/14 for the facility revealed:</p> <ul style="list-style-type: none"> <li>- A sanitation score of 85.</li> <li>- # 32 under Furnishings and Patient Contact Items included 2 demerits for furniture not being clean and in good repair.</li> </ul>	D 076	<p>Completed- chairs have been replaced with tables and chairs.</p> <p>Completed- new sofas have bee purchased.</p> <p>New tables and chairs replaced.</p>	<p>12/3/14</p> <p>12/3/14</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 079	Continued From page 3	D 079	Completed - New staff has been hired for house keeping	12/3/14
D 079	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings</p> <p>(a) Adult care homes shall</p> <p>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain the facility in an uncluttered, clean and orderly manner in 2 of 3 common resident bathrooms (Bathroom #1 and # 2). The findings are:</p> <p>Observation on 11/12/14 at 10:25 a.m. of Common Bathroom # 1 during the facility tour revealed:</p> <ul style="list-style-type: none"> <li>- The tub was rust stained below a rusted hand rail on the tub.</li> <li>- The tub drain area was a green color.</li> <li>- The tub was dirty with remains from bathing and included hairs and pieces of debris.</li> <li>- The common sink had a white corroded covering on the faucet.</li> <li>- There was a window blind had broken and bent and missing slats.</li> </ul> <p>Observation of the shower in Common Bathroom # 2 on 11/12/14 at 10:41 a. m. revealed:</p> <ul style="list-style-type: none"> <li>- A resident was observed to enter the bathroom to take a shower.</li> <li>- A large amount of human hair was accumulated on the floors and collected in the corners of the</li> </ul>	D 079		<p>completed - new staff and current staff have been deep cleaning the facility with lime and rust removal products.</p> <p>completed - new staff has cleaned the shower and makes checks in a minimum of 10 minutes throughout the day.</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 079	<p>Continued From page 4</p> <p>shower stall.</p> <ul style="list-style-type: none"> <li>- A small amount of a black substance was accumulated in the corners and up the wall of the shower stall.</li> </ul> <p>Interview on 11/12/14 at 10:40 a.m. with a resident revealed:</p> <ul style="list-style-type: none"> <li>- The bathrooms had dirty tubs and showers for sometime.</li> <li>- All residents had to use the three common bathrooms.</li> </ul> <p>Interview with the cleaning staff person on 11/12/14 at 11:05 am revealed:</p> <ul style="list-style-type: none"> <li>- Cleaning of the bathrooms was done twice weekly and had been cleaned few days ago.</li> <li>- Floors toilets and shower/tubs were cleaned then.</li> </ul> <p>Interview on 11/12/14 at 10:10 a.m. with the facility cook/housekeeper revealed:</p> <ul style="list-style-type: none"> <li>- There was no deep cleaning schedule in the facility as such.</li> <li>- Baths were wiped down daily and if deeper cleaning was need it was completed.</li> </ul> <p>Interview on 11/12/14 at 5:10 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>- She knew about the condition of some of the issues with the bathrooms.</li> <li>- There was no deep cleaning schedule but bathrooms should be cleaned daily with cleaners and bleach.</li> </ul> <p>Review of the Environmental Health Sanitation Inspection Report dated 6/30/14 revealed:</p> <ul style="list-style-type: none"> <li>- Under comments # 6 indicated there was mold growth in the shower - 1.5 demerits.</li> <li>- Under the Toilet Handwashing, Laundry and Bathing section # 8 - Facilities should be</li> </ul>	D 079	<p>Completed- facility has been deep cleaned. To prevent from reoccurring administrator has hired more staff and cleaning charts have been made.</p> <p><i>D079: TC addendum @ 1/30/15. Administrator. new housekeeping staff hired to ensure the facility is clean &amp; uncluttered. Staff will have a schedule of cleaning maintenance both deep &amp; daily cleaning. The Administrator will monitor bathrooms, residents rooms &amp; other living areas everyday to ensure compliance.</i></p>	
-------	--	-------	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 079	Continued From page 5 convenient clean and in good repair - 2 demerits. Comments # 8 - Bathrooms need cleaning.	D 079		
D 131	<p>10A NCAC 13F .0406(a). Test For Tuberculosis</p> <p>10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record review and interview, the facility failed to assure 3 of 4 sampled staff (Staff A, Staff B, and Staff C) had been tested for Tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services upon employment to assure staff were free of TB disease. The findings are:</p> <p>1. Review of the employee record for Staff A revealed:</p> <ul style="list-style-type: none"> <li>- Staff A was hired by the facility on 4/13/12.</li> <li>- Staff A was hired as a Personal Care Aide/ cook/housekeeper.</li> <li>- There was no documentation of TB testing in the record.</li> </ul> <p>Staff A was not available for interview.</p>	D 131	<p>Completed - documents on file. Copies are included with this form</p> <p>4/30/15 re Addendum - Administrator</p> <ul style="list-style-type: none"> <li>• Staff applicants are required to provide Step 1 TB skin test provide to starting employer</li> <li>• Upon hire, staff will get 2nd step TB skin test.</li> <li>• Administrator will ✓ staff hired files give to hire to ensure staff went or goes to get TB skin test.</li> <li>• Staff records will be maintained &amp; reviewed by RC + for Administrator for TB testing.</li> </ul>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 131	<p>Continued From page 6</p> <p>No TB information for Staff A was provided by the end of the survey.</p> <p>Refer to interview on 11/12/14 at 4:25 p.m. with the Administrator.</p> <p>2. Review of the employee record for Staff C revealed:</p> <ul style="list-style-type: none"> <li>- There was no hire date in the record.</li> <li>- Staff C was hired as a Personal Care Aide</li> <li>- There was no documented TB skin testing in the record.</li> </ul> <p>Staff C was not available for interview.</p> <p>No further TB testing information was provided by the end of the survey.</p> <p>Refer to interview on 11/12/14 at 4:25 p.m. with the Administrator</p> <p>3. Review of the employee record for or Staff B revealed:</p> <ul style="list-style-type: none"> <li>- No hire date found in the record</li> <li>- Staff B was hired as a Personal Care Aide.</li> <li>- There was no documentation of TB skin testing.</li> </ul> <p>Interview with Staff B on 11/12/14 at 3:25 p.m. revealed:</p> <ul style="list-style-type: none"> <li>- Staff B had "grown up in the facility" and had worked there for a long time as a volunteer at first and as a personal care aide.</li> <li>- Staff B had a TB skin test upon starting work in the facility.</li> <li>- No information was provided as to the date of the TB skin testing.</li> <li>- Staff B took the record out of the facility and it was not in this facility at this time.</li> <li>- Staff B would bring the TB documentation back to this facility.</li> </ul>	D 131	<p>Completed - TB skin testing and hire date have been placed in staff folders.</p> <p>Completed</p>	
-------	--	-------	--	--



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 131	Continued From page 8 the Administrator and Co-Administrator would be completed to ensure all staff TB testing documentaion was in the facility. - The Adminsitrator will be responsible for ensuring new hires TB skin testing was obtained and filed in the employe records.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER, 27, 2014.	D 131	<i>Completed- have documents on file</i>	
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: TYPE B VIOLATION  Based on record review and interview, the facility failed to assure 3 of 4 sampled staff (Staff A, B, and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (NCHCPR) according to G.S. 131E-256. The findings are:  1. Review of the employee record for Staff A revealed: - Staff A was hired by the facility on 4/13/12. - Staff A was hired as a Personal Care Aide/cook/housekeeper. - There was no documentation of NCHCPR check in the record.	D 137	<i>Completed- on file</i>  <i>D137 TC @ Administrator Res addendum - HC PR checks Admin + RIC will ensure HCPR check is complete prior to hire. HCPR check will be in staff record prior to hire. RIC + Admin will check staff record for compliance before hire. KMiller DOC 12/3/14</i>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 9</p> <p>No NCHCPR check was provided by the end of the survey.</p> <p>Refer to interview on 11/12/14 at 4:25 p.m. with the Administrator.</p> <p>2. Review of the employee record for or Staff B revealed:</p> <ul style="list-style-type: none"> <li>- No hire date found in the record</li> <li>- Staff B was hired as a Personal Care Aide.</li> <li>- There was no documentation of a NCHCPR check in the record.</li> </ul> <p>Interview with Staff B on 11/12/14 at 3:25 p.m. revealed:</p> <ul style="list-style-type: none"> <li>- Staff B had "grown up in the facility" and had worked there for a long time as a volunteer at first and then as a personal care aide.</li> </ul> <p>No NCHCPR check was provided by the end of the survey.</p> <p>Refer to interview on 11/12/14 at 4:25 p.m. with the Administrator.</p> <p>3. Review of the employee record for or Staff C revealed:</p> <ul style="list-style-type: none"> <li>- There was no hire date in the record.</li> <li>- Staff C was hired as a Personal Care Aide</li> <li>- There was no documented NCHCPR check in the record.</li> </ul> <p>Staff C was unavailable for interview.</p> <p>No NCHCPR check was provided by the end of the survey.</p> <p>Refer to interview on 11/12/14 at 4:25 p.m. with the Administrator.</p>	D 137	Completed	
-------	--	-------	-----------	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 11</p> <p>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination &amp; 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, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interview and record review, the facility failed to assure 2 of 4 sampled residents (# 1, # 3) upon admission had been tested for tuberculosis 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. The findings are:</p> <p>1. Review of the current FL- 2 dated 1/08/14 for Resident # 1 revealed the resident was admitted to the facility on 10/01/13.</p> <p>Review of Resident # 1's record revealed there was no documentation of TB testing.</p> <p>Interview on 11/14/14 at 2:38 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>- She thought all residents and Resident # 1 had been tested for TB disease.</li> <li>- TB results should be in residents' records.</li> <li>- She would look in another notebook where TB testing might be kept for resident TB results.</li> </ul>	D 234	<p>Completed- Administrator will not accept anyone in the facility if client does not have proof of TB skin test.</p> <p>Completed- client tested negative on TB testing. Document included with this form.</p> <p>1/30/15 TC. Addendum to Administration * Resident will have Step 1 TB skin test prior to admission. * 2nd step to be completed prior to admission + will see Administrator for Res responsibility to ensure</p>	
-------	---	-------	--	--

3rd step completed within 1-3 weeks of 15 skintests Res. admission records will be checked 1-3 wk prior to admission to ensure steps 1 + 2 TB skintests completed. A check list will be used. please



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**POOLE'S REST HOME**

**201 MARY JANE BIGELOW ROAD  
YANCEYVILLE, NC 27379**

(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>Based on record review and attempted interview, Resident # 1 was not interviewable.</p> <p>No TB testing was provided by the facility for Resident # 1 by the end of the survey.</p> <p>2. Review of the current FL-2 dated 1/08/14 for Resident # 3 revealed:</p> <ul style="list-style-type: none"> <li>- The resident was admitted to the facility on 12/11/12.</li> <li>- There was documentation on the current FL-2 of a positive TB skin test and the resident was "status post INH" treatment. (Medication for the treatment of TB disease.)</li> <li>- No date for this history of a positive TB skin test was listed.</li> </ul> <p>Review of the record for Resident # 3 revealed there was no documentation of a Record of TB screening having been completed upon admission to the facility.</p> <p>Interview on, 11/12/14 at 2:38 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>- When the resident was admitted to this facility (the resident) she thought the resident had a TB skin test.</li> <li>- The Administrator said the TB testing should be in the resident record.</li> <li>- The Administrator did not know a Department of Health and Human Services Record of TB Screening was to have been completed upon admission.</li> <li>- The Administrator did not provide any information when questioned about if a Record of TB Screening had been completed.</li> <li>- She would look in the resident's other folder for the test results.</li> </ul>	D 234	<p>Completed - Resident tested negative on TB testing.</p> <p>Completed - Resident tested negative. Residents must have proof of TB skin testing before being accepted to the facility to prevent reoccurrence.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 13</p> <p>Interview on 1/12/14 at 2:40 p.m. with Resident # 3 revealed:</p> <ul style="list-style-type: none"> <li>- The resident had a positive TB skin test in the 1990's.</li> <li>- The resident was not treated with medication after the positive TB test.</li> <li>- The resident did not know of any TB testing nor someone asking questions about symptoms of TB disease since admission to this facility.</li> </ul> <p>No TB testing was provided by the facility for Resident # 1. _____</p>	D 234	<p><i>Completed - Resident tested Negative</i></p>	
	<p>Review of the facility's Plan of Protection dated 11/14/14 revealed:</p> <ul style="list-style-type: none"> <li>- All residents without current TB disease testing or a Record of TB Screening as needed would be immediately be tested or screened.</li> <li>- The Administrator would ensure all residents would have TB testing prior to admission to the facility.</li> </ul> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 27, 2014.</p>		<p><i>Completed - to prevent this from reoccurring, administrator will not accept clients who do not have proof of TB skin testing.</i></p>	
D 406	<p>10A NCAC 13F .1009(b) Pharmaceutical Care</p> <p>10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure action was taken to recommendations from the pharmacy medication</p>	D 406		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 406	<p>Continued From page 15</p> <p>gone to the physician's office to get it.</p> <ul style="list-style-type: none"> <li>- The RCC was not aware if any labs had been obtained by the physician including a Valproic Acid level.</li> <li>- She would look for any lab data and also check with the physician's office about Valproic Acid level labs obtained since August 2014.</li> </ul> <p>Interview on 11/12/14 at 4:10 p.m. with the Adminsitrator revealed:</p> <ul style="list-style-type: none"> <li>- She was not aware only the recommendations need to be reviewed by the physician for comment and orders.</li> <li>- No information was provided related to why the pharmacy medication review recommendations had not been followed-up.</li> <li>- There was no information provided related to a system in place to ensure medication review recommendations would be followed up in a timely manner.</li> <li>- A staff member would go and get the reviewed recommendations as soon as possible.</li> </ul> <p>No further information related to the medication review recommendations of 8/15/14 was provided by the end of the survey.</p>	D 406	<p><i>Completed - Dr. April Fields has blood levels</i></p>	
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 observation, interview and record</p>	D912	<p><i>See Tag # D 234, D137 Kmlc.</i></p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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 406	<p>Continued From page 14</p> <p>review for 1 of only 2 facility residents with recommendations. (# 4). The findings are:</p> <p>Review of the current FL-2 dated 5/29/14 for Resident # 4 revealed:</p> <ul style="list-style-type: none"> <li>- Divalproex 500mg twice daily was ordered with no directions for use. (Used to treat seizures and mania.)</li> <li>- Diagnoses of hyperglycemia, cancer and tobacco use.</li> </ul> <p>Review of a subsequent medication order dated 10/07/14 was for Divalproex 500mg 1 by mouth twice daily.</p> <p>Review of the pharmacy medication review dated 8/15/14 revealed:</p> <ul style="list-style-type: none"> <li>- A recommendation was made to be considered by the physician.</li> <li>- The recommendation included, the resident was currently on Divalproex (Valproic Acid).</li> <li>- The recommendation to consider was for Valproic Acid levels with the next set of labs obtained.</li> </ul> <p>Review of the record for Resident # 4 revealed:</p> <ul style="list-style-type: none"> <li>- There was no documented follow-up to the 8/15/14 medication review recommendations by the pharmacist.</li> <li>- There were no lab data or documentation of Valproic Acid level labs ordered nor obtained since the 8/15/14 medication review.</li> </ul> <p>Interview on 11/12/14 at 12:45 p.m. with the Resident Care Coordinator revealed:</p> <ul style="list-style-type: none"> <li>- All of the pharmacy medication reviews and the recommendations from 8/15/14 were still at the physician's office since August 2014.</li> <li>- The recommendation for Resident # 4 had not been returned to the facility and they had not</li> </ul>	D 406	<p>Completed. bloodwork was done on 10/16/14. Documentation is included in this form.</p> <p>D 406 - 1/30/15 TC &amp; Administrator addendum: Pharmacy review recommendations are forwarded to the physician for review within 1 week of the recommendation. The RAC / Administrator will ensure physician review recommendations within 2 wks to ensure recommendations are completed in a timely manner. K.M. Miller</p>	
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL017006</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/12/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>POOLE'S REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 MARY JANE BIGELOW ROAD YANCEYVILLE, NC 27379</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
--------------------	--	---------------	---	--------------------

D912	<p>Continued From page 16</p> <p>review, the facility failed to assure resident's received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to and staff Tuberculosis (TB) testing, resident testing for TB and NC Health Care Personnel Registry (NCHCPR) checks for staff. The findings are:</p> <ol style="list-style-type: none"> <li>1. Based on record review and interview, the facility failed to assure 3 of 4 sampled staff (Staff A, Staff B, and Staff C) had been tested for Tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services upon employment to assure staff were free of TB disease. [Refer to Tag 0131, 10A NCAC 13F .0406 (a) Tuberculosis Testing and Examination. (Type B Violation.)]</li> <li>2. Based on record review and interview, the facility failed to assure 3 of 4 sampled staff (Staff A, B, and C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (NCHCPR) according to G.S. 131E-256. [Refer to Tag 0137, 10A NCAC 13 F .0407 (a) Other Staff Qualifications. (Type B Violation.)]</li> <li>3. Based on interview and record review, the facility failed to assure 2 of 4 sampled residents (# 1, # 3) upon admission had been tested for tuberculosis 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. [Refer to Tag 0234, 10A NCAC 13 F .0703 (a) Tuberculosis Testing and Examination. (Type B Violation.)]</li> </ol>	D912	<p><i>Completed - Administrator will make sure residents have TB skin test before admission.</i></p> <p><i>Completed - Resident tested negative</i></p>	
------	---	------	---	--

Handwritten text, possibly a list or notes, located in the upper left quadrant of the page. The text is faint and difficult to read.

Handwritten text, possibly a list or notes, located in the lower left quadrant of the page. The text is faint and difficult to read.

## Herring, Belverly G

---

**From:** Miles, Karen  
**Sent:** Monday, February 09, 2015 12:59 PM  
**To:** mwaddell@caswellcountync.gov  
**Cc:** Griffis, Angela; Herring, Belverly G  
**Subject:** Poole's Rest Home  
**Attachments:** Poole's Rest Home 2014 12-17 POCA 5NQ011.pdf

Dear Michelle,

Please find the Plan of Correction with addendum attached to this email.

Please contact this office with questions at 919-855-3765.

Sincerely,

Karen L. Miles

Karen L. Miles RN, CNM, Nurse Consultant  
N.C. Department of Health and Human Services  
Division of Health Service Regulation  
Adult Care Licensure Section  
805 Biggs Drive, Raleigh N. C. 27603  
Phone: 919-855-3765  
Fax: 919-933-9379  
[karen.miles@dhhs.nc.gov](mailto:karen.miles@dhhs.nc.gov)  
<http://www.ncdhhs.gov/dhsr/acis/index.html>

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 email in error, please notify the sender immediately and delete all records of the email.