

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fcl079067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ <i>sl</i>	(X3) DATE SURVEY COMPLETED 09/12/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER FAITHWORKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 814 LINDSEY STREET REIDSVILLE, NC 27320 <i>County: Rockingham</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
--------------------	--	---------------	---	--------------------

C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 12, 2014.	C 000		
C 074	<p>10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings</p> <p>10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure the walls and floors were kept clean and in good repair.</p> <p>The findings are:</p> <p>Observation and tour of the facility on 09/12/14 at 8:30 am revealed: -Four male residents and two female residents resided at the facility.</p> <p>1. Observation and tour of the physical building revealed: -The men's common bathroom had a foul odor of urine and was in need of cleaning and repairs as follows: -The toilet was dirty and stained with dark brown substance. -The wall in front of the toilet had several smudged black marks that extended 3 feet down the wall to the floor and 4 feet the length of the wall. -The same black scuff marks were identified on the bathroom door inside and outside and on the</p>	C 074	<p><i>The BATH ROOMS Have Been cleaned, Repaired and Painted And will be maintained</i></p>	<p><i>9/19/14</i></p>

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jack Martin Jr* TITLE *SIC* (X6) DATE

POC Approved, with addendum per H. Hawkins / sl 03-30-15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fcl079067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

FAITHWORKS ASSISTED LIVING 814 LINDSEY STREET
REIDSVILLE, NC 27320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 074	<p>Continued From page 1</p> <p>two drawers of the vanity cabinet.</p> <p>2. Observation of the kitchen revealed: -A 12 inch by 13 inch circular spot in the ceiling above the cabinets and countertop appeared to be from water damage. -The plaster of the ceiling was missing. -The dry wall was showing with several layers were of plaster identified. -Water spots were identified on the dry wall in the ceiling. -The paint on the was blistered around the damaged area.</p> <p>Interview on 09/12/14 at 11:00 am with the Supervisor-in-Charge (SIC) revealed: -The roof has a leak. -Several times the building owner plastered ceiling where the rain leaked through. -Every time it rained the water ruined the ceiling plaster causing it to blister and chip off. -The building owner had searched and was unable to find the leak.</p> <p>Confidential interview with three residents revealed: -When it rained the roof in the kitchen leaked. -They never got wet because the leak was over the counter top. -The leak had been repaired about two months ago, but the same thing happened every time it rained.</p>	C 074	<p>The roof LEAK HAS BEEN REPAIRED AND APPEARS TO BE LEAK FREE NOW.</p>	11/11/15
C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination</p> <p>(a) Upon admission to a family care home each</p>	C 202		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fc1079067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER FAITHWORKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 814 LINDSEY STREET REIDSVILLE, NC 27320
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

C 202	<p>Continued From page 2</p> <p>resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 sampled residents (Resident #3) was tested for tuberculosis (TB) disease upon admission to the facility in compliance with the control measures adopted by the Commission for Health Services.</p> <p>The findings are:</p> <p>Review of Resident #3's record revealed: -The resident was admitted to the facility on 07/30/13. -No documented TB test was in the record.</p> <p>Interview on 09/12/14 at 1:10 pm with Resident #3 revealed: -Prior to coming to the facility he was in the hospital and no TB test was done. -Prior to going to the hospital he lived in another home and recalled being tested for TB. -Since he moved to this facility in July 2013 he had not been tested for TB.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 09/12/14 at 1:13 pm revealed: -Last year a lot of places were out of the TB serum and they were unable to get a TB test for Resident #3. -He had not checked with any organizations since</p>	C 202		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fc1079067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER FAITHWORKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 814 LINDSEY STREET REIDSVILLE, NC 27320
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	<p>Continued From page 3</p> <p>last year to inquire if the TB serum was now available.</p> <p>-He was unaware that some organizations had the TB serum and Resident #3 could be tested.</p> <p>-The Administrator was responsible to ensure TB testing was done on new residents admitted to the facility.</p> <p>Interview with the Administrator on 09/12/14 at 2:00 pm revealed:</p> <p>-It was her responsibility to ensure TB test were done on new residents.</p> <p>-Last year when Resident #3 was admitted to the facility the TB test serum was not available.</p> <p>-Later she forgot to check if TB serum was available for testing Resident #3.</p>	C 202	<p>RESIDENT #3 completed 2 STEP TB TESTING.</p> <p>All RESIDENTS ADMITTED going FORWARD will HAVE TESTING DONE ASAP</p>	10/3/14
C 934	<p>G.S.131D-4.5B (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p>	C 934	<p>AFTER several cancellations due to weather, all STAFF HAVE received necessary TRAINING. WILL INSURE TRAINING IS DONE ANNUALLY FROM NOW ON.</p>	3/4/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fc1079067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/12/2014
--	---	---	--

NAME OF PROVIDER OR SUPPLIER FAITHWORKS ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 814 LINDSEY STREET REIDSVILLE, NC 27320
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 934	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 1 staff (Supervisor in Charge/Medication Aide) employed more than one year received mandatory annual infection prevention training.</p> <p>The findings are:</p> <p>A. Review of Staff C's (Supervisor-in-Charge) personnel record revealed: -A hire date of 04/01/11. -Documentation of successful Medication Aide Testing results dated 11/01/10. -No documentation of mandatory infection control training or any other type of similar training.</p> <p>Staff C was not available for interview.</p> <p>Interview on 09/12/12 at 3:25 pm with the SIC on duty revealed: -Staff C had worked at the facility since April 2011. -Currently no residents at the facility required insulin injection or finger stick blood sugar monitoring. -Staff C job duties and responsibilities included the administration of eye drops and inhalers. -It was the Administrator's responsibility to ensure required training was completed.</p> <p>B. Review of Staff B's (Supervisor-in-Charge) personnel record revealed: -A hire date of 07/12/08. -Documentation of successful Medication Aide Testing results dated 06/07/10. -No documentation of mandatory infection control training.</p>	C 934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: fcl079067	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/12/2014
NAME OF PROVIDER OR SUPPLIER FAITHWORKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 814 LINDSEY STREET REIDSVILLE, NC 27320		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 934	<p>Continued From page 5</p> <p>-Documentation of Blood Borne Pathogens training completed in April 2014.</p> <p>Interview with the SIC on 9/12/14 at 11:45 am revealed:</p> <ul style="list-style-type: none"> -He worked 24/7 and resided in the facility. -He was responsible for day to day facility management and medication administration. -Currently, no residents at the facility received injections or finger stick blood glucose monitoring. -He did administer eye drops and inhalers. -He was unaware of the requirement for annual mandatory Infection Control course and training. -The Administrator scheduled the training classes and he just attended as required. -The blood borne pathogens training class was the only one he recalled taking. <p>Interview on 09/12/14 at 12:40 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She recently had a stroke and was unable to perform the duties of medication administration. -Staff's A and B were responsible to medication administration and administering eye drops and inhalers. -It was her responsibility to assure trainings were done. -She was aware the annual mandatory infection control training was required. -But she thought the blood borne pathogens training was sufficient for the requirement. <p>Per the Administrator/Owner on 03/30/15, all rule areas cited above (.0315(a)(1), .0702(a) and G. S. 131D-4.5B(a) will be monitored by her weekly to ensure compliance. Typed by Keturah E. H. Hawkins</p>	C 934		

Shook, Linda

From: Hawkins, Harriett
Sent: Monday, March 30, 2015 10:36 PM
To: Ferrell, Felissa
Cc: Harrison, Carolyn; Shook, Linda
Subject: Faithworks Assisted Living 2015-03-09 POC 7IPO11
Attachments: FAITHWORKS ASSISTED LIVING 2015-03-09 POC-7IPO11 REVIEW.pdf

Attached please find the approved POC with added monitoring plan.

Keturah-Elizabeth Harriett Hawkins, MHA
N.C. Department of Health and Human Services
Facility Survey Consultant I
Adult Care Licensure Section
Division of Health Service Regulation
12 Barbetta Drive, Asheville, NC 28806
(P) 336-341-8129
(F) 828-670-5040
Harriett.hawkins@dhhs.nc.gov

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 this email.