

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL020002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2015
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NAME OF PROVIDER OR SUPPLIER CAROLINA CARE HOME # 2	STREET ADDRESS, CITY, STATE, ZIP CODE 4025 PIGAH ROAD ANDREWS, NC 28901
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments	D 000		
D 078	<p>10A NCAC 13F .0306(a)(5) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations and interviews, the facility failed to ensure the environment was uncluttered and free of safety hazards by placing 3 un-racked oxygen cylinders, 2 racked oxygen cylinders, 15 cardboard boxes and an oxygen concentrator in the vicinity of the main entrance. The facility also failed to keep clean 4 of 4 fans and an air return vent.</p> <p>The findings are:</p> <p>Observations on 3/10/15 at 9:30am, upon entry through the main entrance into the facility, revealed the following items positioned in the entryway and along a half wall separating the entryway from the dining room: -An oxygen concentrator. -An M-24 size oxygen cylinder with an attached</p>	D 078		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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D 078	<p>Continued From page 1</p> <p>regulator in a metal wheeled rack. -An M-60 size oxygen cylinder in a metal rack. -(3) M-24 size oxygen cylinders, un-racked and sitting directly on the floor with the stems of the tanks (where a regulator would be attached) covered in white tape. -A total of 15 cardboard boxes of various sizes in three stacks approximately 4 feet high, immediately adjacent to the 3 un-racked oxygen cylinders, the boxes containing exam gloves, incontinence briefs and absorbent pads.</p> <p>An observation on 3/10/15 at 9:45am during the initial tour revealed: -An air return vent in the ceiling in the living room covered in a thick coat of dust. -An operating box fan on the floor in the living room covered in a thick coat of dust. -An operating box fan on the floor in the men's hallway covered in a thick coat of dust.</p> <p>An interview on 3/10/15 at 10:15am with the Personal Care Aide revealed: -The oxygen tanks in the entryway were full. -A resident in the facility refused to wear oxygen and as long as there was a medical order the facility had to keep the oxygen. -The stacked boxes contained resident supplies and there was no storage space for the boxes.</p> <p>An observation on 3/10/15 at 10:25am revealed an operating oscillating fan on a stand in the women's hallway covered in a thick coat of dust.</p> <p>An observation on 3/10/15 at 11:05am revealed an operating box fan on the floor of the kitchen covered in a thick coat of dust.</p> <p>An interview on 3/10/15 at 12:10pm with the Administrator revealed:</p>	D 078		

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D 078	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The oxygen tanks were in the entryway awaiting pick-up by the medical supplier on 3/12/15. -The medical supplier did not put oxygen tanks in racks and in the past had been asked to. -The oxygen tanks had been at the entryway for 2 or 3 days. -The boxes of supplies in the entryway were delivered on 3/9/15 (yesterday) and were waiting for a truck to come and take them to another storage area on the facility's property. -There were no smokers in the facility and all residents were ambulatory without any recent falls. <p>Another interview on 3/10/15 at 12:32pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She had called the medical supplier who would pick up the oxygen tanks "shortly." -She did not know oxygen tanks should be stored in racks for safety. <p>Another interview on 3/10/15 at 12:55pm with the Administrator revealed fans should be kept clean and she would have them removed to the back hall of the facility for cleaning.</p> <hr/> <p>A Plan of Protection was obtained from the Administrator on 3/10/15 at 12:55pm which included the following:</p> <ul style="list-style-type: none"> -The 3 un-racked oxygen tanks were immediately removed and relocated to the staff office and placed there so as to prevent anyone from bumping into them. -The physician was notified to write a discontinuation order for the oxygen so that medical supplier would pick it up. -Any future oxygen tanks for residents would be stored appropriately. 	D 078		

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D 078	Continued From page 3 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 24, 2015.	D 078		
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 and interviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to removing safety hazards, clutter and housekeeping.</p> <p>The findings are:</p> <p>Based on observations and interviews, the facility failed to ensure the environment was uncluttered and free of safety hazards by placing 3 un-racked oxygen cylinders, 2 racked oxygen cylinders, 15 cardboard boxes and an oxygen concentrator in the vicinity of the main entrance. The facility also failed to keep clean 4 of 4 fans and an air return vent. [Refer to Tag D 078 10A NCAC 13F .0306(a)(5) (Type B Violation)]</p>	D912		