STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	HAL031017		06/18/2015

NAME OF PROVIDER OR SUPPLIER
DAYSPRING OF WALLACE

STREET ADDRESS, CITY, STATE, ZIP CODE
4026 HIGHWAY 11 SOUTH
WALLACE, NC 28466

(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 Duplin County Department of Social Services conducted an annual survey on June 16, 2015 , June 17, 2015 and June 18, 2015.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that 3 of 5 sampled medication aides (Staff E, F and H) received training by a licensed health professional on the care of	D 164		

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D 164	Continued From page 1 diabetic residents prior to administering insulin to residents. The findings are: 1. Review of Staff E's personnel record revealed: - She was hired as a Supervisor in Charge (SIC)/ Medication Aide on 1/27/12. - She completed the Medication Clinical skills validation on 2/15/12. - She passed the Medication Aide exam on 1/11/07. - There was no documentation of training on the care of residents with diabetes. Review of facility's Medication Administration Record (MAR) revealed that Staff E administered insulin during April, May and June of 2015. Staff E was not available for interview. Refer to review of facility residents' records. Refer to interview with Administrator on 6/18/15 at 3:45 P.M. 2. Review of Staff F's personnel record revealed: - She was hired as a Personal Care Assistant (PCA) on 6/14/11. - She passed the Medication Aide exam on 9/22/11. - She completed the Medication Clinical skills validation on 2/16/12. - She was then hired as a Supervisor in Charge (SIC) on 6/19/12. - There was no documentation of training on the care of residents with diabetes. Review of facility's Medication Administration Record (MAR) revealed that Staff F administered insulin during April, May and June of 2015.	D 164		

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D 164	Continued From page 2 Interview with Staff F on 6/18/15 at 3:55 P.M. revealed that she did not recall having had a class on the care of residents with diabetes. Refer to review of facility residents' records. Refer to interview with Administrator on 6/18/15 at 3:45 P.M. 3. Review of Staff H's personnel record revealed: - She was hired as a Supervisor in Charge (SIC) on 3/09/15. - She completed the Medication Clinical skills validation on 11/07/13. - She passed the Medication Aide exam on 8/01/90. - There was no documentation of training on the care of residents with diabetes. Review of facility's Medication Administration Record (MAR) revealed that Staff H administered insulin during April, May and June of 2015. Interview with Staff F on 6/18/15 at 4:00 P.M. revealed that she did not recall having had a class on the care of residents with diabetes. Refer to review of facility residents' records. Refer to interview with Administrator on 6/18/15 at 3:45 P.M. _____ Review of facility residents' records revealed: - Current census of 68 residents. - Twenty-four of which are diabetics. - Eight residents who receive scheduled insulin and six residents who receive sliding scale insulin Interview with Administrator on 6/18/15 at 3:45	D 164		

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D 164	Continued From page 3 P.M. revealed: - The Resident Care Coordinator (RCC) and the Memory Care Coordinator (MCC) usually keeps up with the training of the staff. - Currently the MCC position is vacant around a week and one half now. - The RCC is currently working both positions. - Will review all Medication Aide personnel record to make sure that they have had the required training on the care of residents with diabetes.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 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. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 2 of 5 residents (#1, #4) sampled as related to coordinating to get pacemaker checks for a resident (#4) and coordinating to get toenail care for a resident (#1) with toenails too thick to be cut by facility staff. The findings are: 1. Review of Resident #4's current FL-2 dated 03/06/15 revealed diagnoses included hypertension, diabetes mellitus type II, dementia, and urinary tract infection. Review of Resident #4's Resident Register revealed the resident was admitted to the facility	D 273		

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D 273	Continued From page 4 on 11/19/13. Review of Resident #4's current assessment and care plan signed by the physician on 03/11/15 revealed: - The resident required extensive assistance with all activities of daily living. - The resident was sometimes disoriented and had significant memory loss and must be redirected. Review of hospital emergency room forms dated 11/22/14 revealed: - Resident #4 was sent to the emergency room related to symptoms of urinary tract infection. - Documentation on the hospital forms noted the resident had a pacemaker. (A pacemaker is a small battery operated device implanted under the skin that delivers electrical impulses to the heart muscles in order to keep the heart beating normally. Pacemaker leads are insulated electrical wires that carry electrical impulses from the pacemaker to the heart.) - A chest x-ray was performed and the pacemaker leads were noted to be in place. - An electrocardiogram was performed and documentation noted, "electronic atrial pacemaker [pacemaker rhythm beat (beat 1, 2, 3...)]". Review of the lab section in Resident #4's record revealed one pacemaker check dated 01/15/14. Review of a chest x-ray from a hospital visit for weakness dated 03/04/15 revealed: - There was no acute abnormality. - Findings included "left pacemaker 2 leads". - No other documentation related to the pacemaker.	D 273		

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D 273	Continued From page 5 Interview with the Resident Care Coordinator (RCC) and Administrator on 06/17/15 at 4:00 p.m. revealed: - They were unaware Resident #4 had a pacemaker. - They would check with the primary physician. Interview with the RCC and Administrator on 06/18/15 at 1:00 p.m. revealed: - The last pacemaker check they were able to find documented was 01/15/14. - They contacted the primary physician and he was unaware Resident #4 had a pacemaker. - The primary physician referred the resident to cardiology. - They scheduled an appointment with cardiologist for 06/30/15. Interview with RCC on 06/18/15 at 3:00 p.m. revealed: - A family member told the RCC when the resident came to the facility, the facility transporter took the resident to an appointment to get her pacemaker checked. - After that, the facility's transporter was out on medical leave and they had at least 3 different transporters since then. - The facility transporter was responsible for setting up appointments. - She was unaware of a monitoring system to make sure residents were taken to appointments. - She thought the pacemaker checks "fell through the crack" after the transporter went out on medical leave. Telephone interview with the nurse at the primary physician's office on 06/18/15 at 3:15 p.m. revealed: - The primary physician was aware the first appointment available with the cardiologist was	D 273		

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D 273	Continued From page 6 on 06/30/15. - The physician told the nurse it was okay to wait to see the cardiologist until the appointment on 06/30/15. Interview with the facility Transporter on 06/18/15 at 3:25 p.m. revealed: - She took Resident #4 for the pacemaker check in January 2014. - She went on medical leave in March 2014. - Transporter was responsible for making appointments and documenting in the appointment book. - Resident #4 was supposed to go every 3 months for pacemaker checks. - She did not know if a follow-up appointment was made after she took the resident in January 2014. - She returned back to work at the facility this year in 2015. - She would try to find the appointment book for 2014 to see if an appointment was scheduled after she went on leave in March 2014. Telephone interview with a representative from the cardiologist's office on 06/18/15 at 3:30 p.m. revealed: - Resident #4's pacemaker was a dual chamber pacemaker and was implanted on 06/03/09. - Those types of pacemakers usually required checks every 3 to 4 months depending on the patient. - She was unable to check records to determine if Resident #4 had missed any scheduled appointments. - The resident's pacemaker was last checked in January 2014. Interview with Resident #4's family member on 06/18/15 at 4:30 p.m. revealed:	D 273		

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D 273	Continued From page 7 - Another family member took Resident #4 to have the pacemaker checked when she was first admitted to the facility in November 2013. - The facility took the resident for another pacemaker check in January 2014. - The resident's pacemaker was supposed to be checked every 3 months. - She recalled the facility transporter got sick after the appointment in January 2014. - The pacemaker checks "must have been overlooked" after that. - The resident had never had any problems with the pacemaker. Based on observation, interview, and record review, Resident #4 was not interviewable due to diagnoses of dementia. 2. Review of Resident #1's current FL-2 dated 03/06/15 revealed diagnoses of atrial fibrillation, sick sinus syndrome, Alzheimer's disease, depression, and fracture of the left proximal humerus. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 12/08/06. Review of Resident #1's current assessment and care plan signed by the physician on 03/11/15 revealed: - The resident required extensive assistance with all activities of daily living. - The resident was verbally abusive, physically abusive, and resisted care. - Resident was always disoriented. - Resident had significant memory loss, and must be directed. Observation of Resident #1 during the initial tour	D 273		

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D 273	Continued From page 8 of the facility on 6/16/15 at 11:00am revealed: - He was sitting in a wheelchair at a dining room table and was consuming a snack. - The wheelchair did not have foot rests. - He was wearing heel protectors. - The nails of both great toes were extended approximately 1/4th inch beyond the end of the toes, were approximately 1/8th inch thick, were dark yellow in color, and had dark brown-black debris collected under the nails and along the edges/cuticles. Interview with Resident #1 at 11:30am on 6/16/15 revealed: - He wore the foam heel protectors because he had blisters on his feet. - A nurse came to change the bandages on his feet every couple of days. - The nurse did not cut his toenails for him. - No one has cut his toenails for him. - His toenails were fine, he did believe they need to be cut. - He sometimes wore his own slippers instead of the slippers [heel protectors] provided by the nurse. - He does not wear any other shoes, "The slippers are fine, I can take them off by myself". Observation of Resident #1 on 6/18/15 at 11:30am revealed: - Resident was ambulating in a wheelchair. - Resident wore black slippers with polarfleece lining on both feet. Resident was asked to remove his slippers on 6/18/15 at 11:35am on 6/18/15. Continued observation of Resident #1's feet revealed: - Resident had gauze bandages on both heels. - The gauze bandages were loose, and lightly soiled with gray dust and debris.	D 273		

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D 273	Continued From page 9 - The nails of both great toes were extended approximately 1/4th inch beyond the end of the toes, were approximately 1/8th inch thick, were dark yellow in color, and had brown dirt and debris collected under the nails and along the edges/cuticles. - The nail of the great toe on the right foot had bright red dried blood along the left side of the toenail. The nail appeared to be torn along the left side of the toe (no toe next to the tear). - The nail of the second toe on the left foot had grown long enough to curve down over the top half of the front of the toe. - All nails on the 8 smaller toes were light yellow-brown in color, jagged, and extending 1/8th inch beyond the toe. The Supervisor-in-Charge (SIC) of the Special Care Unit observed Resident #1's feet and toes at 11:35am on 6/18/15. She knelt down to the floor and cradled his right heel in her hand. The resident was observed to wince when she touched his feet. Further interview with Resident #1 at 11:35pm on 6/18/15 revealed: - His feet were fine. - His heels were sore sometimes. - He did not need to have his toenails cut. - He did not want a change of clean bandages on his heels. - The bloody toe did not hurt, "Don't touch my feet". - He did not want anyone touching his feet anymore. Interview with the SIC at 11:45am on 6/18/15 revealed: - Resident #1 was resistive to care. - Resident #1 was verbally abusive to staff.	D 273		

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D 273	Continued From page 10 - Resident #1 talked nonstop, he talked about every thought that came into his head, and often did not answer questions appropriately. - Staff had to continually repeat information, options, and questions to perform care for him and to remind him to stay on track of conversations/questions with them. - Resident #1 was a poor historian, due to diagnosis of Alzheimer's disease. - She did not refer Resident #1 for podiatry services due to lack of insurance coverage. - Resident #1 was not eligible for podiatry services under Medicare/Medicaid, "because he did not have a diagnosis of diabetes". - "His toenails were too thick to be cut by facility staff". - Staff would not cut his toenails due to his refusals, his abusive nature, and because they were too long and thick. - She had not contacted his guardian or his physican to inform them of his need for podiatry services. Further interview with the SIC at 3:45pm on 6/18/15 revealed: - She will contact Resident #1's guardian and his physician to inform them of his toenail problems. - She will request a podiatry referral and appointment for Resident #1 from the physician. - She will confer with the Administrator to find a payment source for the podiatry appointment. - The facility transporter was responsible for setting up appointments. - Transporter was responsible for making appointments and documenting in the appointment book. Resident #1's guardian was not available for interview.	D 273		

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D 273	Continued From page 11 Facility transporter was not available for interveiw.	D 273		
D992	G.S.§ 131D-45 Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (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.	D992		

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D992	Continued From page 12 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that an examination and screening for the presence of controlled substances was performed for 2 of 6 sampled employees (Staff B and C) prior to employment. The findings are: 1. Review of Staff B's personnel record revealed: - She was hired on 11/05/13. - She was hired as a Personal Care Assistant (PCA). - There was no documentation in personnel record of completion of an examination and screening for the presence of controlled substances. Interview with Staff B on 6/18/15 at 4:05 P.M. revealed that she did not recall having had a controlled substance exam and screening done before being hired by facility. Refer to interview with Administrator on 6/18/15 at 3:45 P.M. 2. Review of Staff C's personnel record revealed: - She was hired on 4/07/14. - She was hired as a Supervisor in Charge (SIC). - There was no documentation in personnel record of completion of an examination and screening for the presence of controlled substances. Staff C was not available for interview. Refer to interview with Administrator on 6/18/15 at 3:45 P.M.	D992		

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D992	Continued From page 13 _____ Interview with Administrator on 6/18/15 at 3:45 P.M. revealed: - Facility was not aware that Staff B and Staff C needed to complete a controlled substance exam and screening before they were hired. - Was not aware that the regulations requiring a controlled substance exam and screening became effective 10/1/2013. - That if a controlled substance exam and screening was done, it would be filed along with the criminal background check.	D992		

Division of Health Service Regulation

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	HAL034098		06/24/2015

NAME OF PROVIDER OR SUPPLIER
SALEM TERRACE

STREET ADDRESS, CITY, STATE, ZIP CODE
2609 OLD SALISBURY ROAD
WINSTON SALEM, NC 27127

(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 staff conducted an annual survey and follow up on June 23, 2015 and exited on June 24, 2015.	D 000		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. The findings are: Observation on 06/23/15 at 9:40 am upon entrance to the facility revealed: -The sanitation score was 84 based on a local Environmental Health inspection completed on 06/09/15. -There were two damaged flooring tile areas, one at the door entrance to the medication room and the other in the door way of the dining room, in the Special Care Unit (SCU). -The main entrance hallway in the SCU had a	D 077		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	HAL034098		06/24/2015

NAME OF PROVIDER OR SUPPLIER
SALEM TERRACE

STREET ADDRESS, CITY, STATE, ZIP CODE
2609 OLD SALISBURY ROAD
WINSTON SALEM, NC 27127

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D 077	Continued From page 1 sticky residue that shoes would stick to the floor when walked on. Review of the facility's current Environmental Health inspection report dated 06/09/15 revealed: -The inspection included demerits related to walls, floors, lighting, toilet, vermin control, proper disinfectant use, removal of solid waste and vacuum breakers missing on shower heads. Observation on 06/24/15 at 11:30 am of the rooms noted on the Environmental Health Inspection report revealed: -The rooms were 106, 112, 514, 509, 505, 501, 502, 400, 407, 402, 405, 312, 310, 304, 203, 206. -The findings had been corrected and/or were under repair. Interview on 06/24/15 at 9:45 am with the Administrator revealed: -She was aware of the 84 sanitation score. -She had requested a re-inspection because she did not agree with the sanitation score of 84. -The demerits on the sanitation report had been corrected and were "little" things except the bathroom in the SCU, which was being repaired the next week coming. Interview on 06/24/15 at 10:40 am with the Maintenance Director revealed: -The local Environmental Health Department had conducted the annual inspection about two weeks ago. -The Environmental Health Inspector had noted normal wear and tear where wheel chairs had rubbed the walls. -The Environmental Health Inspector had also noted where walls had been patched and repaired, but not yet painted. -There were no actual holes in the walls or in the	D 077		

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D 077	Continued From page 2 floors. -The Environmental Health Inspector had stated that he would return to the facility and conduct another inspection when the Maintenance Director called and advised him that the repairs had been made, and this would possibly result in an increased sanitation score. -The facility had 7 resident rooms and 7 resident bathrooms on the list for repairs. -The corporate office was aware of the local Environmental Health inspection score and the need for the repairs. -The facility employed one full-time maintenance employee and one part-time maintenance employee. Interview via telephone with Resident #2's family member on 06/24/15 at 11:00 am revealed: -The sticky residue had been on the floor since March. -The stickiness was worse on some days than others. -She had noticed housekeeping cleaning the floors multiple times on her visits to the facility. Interview on 06/24/15 at 1:00 pm with the Environmental Services Manager revealed: -The sticky flooring in the SCU was done by the previous Environmental Service contract group. -The previous company had used a floor buffing machine on the flooring that damaged the top layer of the laminate surface causing the surface to be sticky. Interview on 06/26/15 at 8:45 am with the Environmental Health Inspector revealed: -The facility had received several complaints regarding cleanliness. -As of this date (June 26, 2015) no request had been made by the facility for a follow-up	D 077		

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D 077	Continued From page 3 inspection.	D 077		