

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/05/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 2-5, 2015.	{D 000}		
{D 072}	<p>10A NCAC 13F .0305(m) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure the outside grounds of the facility were maintained in a clean and safe condition.</p> <p>The findings are:</p> <p>Observation on 6/5/15 at 4:20pm revealed:</p> <ul style="list-style-type: none"> - The back side of the building had faded white and black paint on the walls. - The front left side of the building had a ladder and a large paint can on the ground. - The storage shed was covered in peeling paint. - Two very large facility signs were leaned against the right side of the shed. - Two of the four sign posts, on this sign had concrete chunks attached where they had been imbedded in the ground. - A large stack of white plastic water pipes and black drainage pipes were piled up next to the 	{D 072}	 <p style="text-align: center;">RECEIVED SEP 14 2015 ADULT CARE LICENSURE SECTION RALEIGH</p> <p style="font-size: 2em; font-family: cursive;">maintenance department will clean up around the building and take away all unwanted equipment from around the</p> <p style="font-size: 2em; font-family: cursive; position: absolute; right: 0; top: 50%;">10-8-15</p>	

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

Lisa Boyer

TITLE

manager

(X6) DATE

9-10-15

*kg
9/28/15*

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{D 072}	<p>Continued From page 1</p> <p>shed on the left side.</p> <p>Observation on 6/5/15 at 4:20pm revealed there were still multiple items sitting outside the storage building in the back yard of the building such as a rusty bedframe, 6 mattresses, a recliner with ripped upholstery, Geri-chair, bedside commode, bedside dresser, and multiple stacks of bricks.</p> <p>Observation on 6/2/15 at 4:25pm revealed:</p> <ul style="list-style-type: none"> -There was a brick area on the outside smoking courtyard next to the activity room. -The ground was exposed where an area 5 by 5 feet of missing bricks presented a trip hazard. -Multiple smokers walked in and out of the smoking area. -The ground underneath some of the bricks was uneven. <p>Observation on 6/5/15 at 6:10pm revealed:</p> <ul style="list-style-type: none"> -The brick patio smoking area still contained missing bricks and an uneven terrain. <p>Two confidential staff interviews revealed:</p> <ul style="list-style-type: none"> -Staff did not believe the items around the facility's storage shed presented a safety concern for the residents. -There used to be more items around the shed and the facility's maintenance man had removed them. <p>Interview with a resident on 6/2/15 at 10:56 am revealed the resident had no problems with the outside premise.</p> <p>Interview with a second resident on 6/2/15 at 11:19am revealed the resident had no problems with the outside cleanliness of the facility.</p> <p>Interview with a third resident on 6/2/15 at 11:45am revealed:</p>	{D 072}	<p>building. And maintenance will monitor 3 times a week.</p> 	<p>10-8-15</p>
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{D 072}	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The outside of the building was clean. -The yard had been mowed 3-4 days ago. <p>Interview with a fourth resident on 6/2/15 at 3pm revealed the resident was unsure how often the outside of the building was cleaned.</p> <p>Interview with the facility Manager on 6/5/15 at 6:15pm revealed:</p> <ul style="list-style-type: none"> -She was aware there were still items around the facility's storage shed. -There were only certain days the dump was open to discard items around the storage shed. -The owner had told staff he had plans to get rid of the items around the facility's storage shed but had not told staff in what time frame. -No residents had tripped or gotten hurt because of the missing bricks. -She had talked with the maintenance man about removing the bricks and starting all over to redesign this area as a patio. -She did not know when the remodeling was going to start. -The maintenance man was very busy as he has to cover 2 facilities. -The maintenance man was not available for an interview. <p>The Maintenance man could not be reached by the end of the survey.</p> <p>The Administrator was not available for interview.</p>	{D 072}		<p>10-8-15</p>
{D 074}	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p>	{D 074}		

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{D 074}	Continued From page 3 (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Non-compliance continues	{D 074}	↓	10-8-15
→ D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 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. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the facility did not use hazardous insecticide sprays inside of the facility. The findings are: Observations of resident room 106 on 6/03/15 at 11:45 a.m. revealed: - Multiple flies in a resident's room. - Several flies were crawling around on the bed. - Four flies were moving around on the top of the dresser. - Two flies were on the side table near the window. - Three flies were on the window sill. Interview on 6/03/15 at 11:45 a.m. with two residents in the room revealed:	D 079	Administrator is consulting with a company, to see what fly spray is safe to use around the residents, in the facility, so we can continue to put them in the sprayers throughout the facility, to make sure we do not have a Big Fly problem	9-30-15

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- D 079	<p>Continued From page 4</p> <ul style="list-style-type: none"> - There were flies off and on in rooms lately. - They were bothersome at times but were not so bad today. <p>Observation on 6/04/15 at 11:30 p.m. of three resident rooms on the 100 Hall revealed each room had two - five flies on the furniture and two - three flies on the beds.</p> <p>Interview on 6/04/15 at 11:35 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - There were many flies in the facility at different times of the year. - They were better yesterday with the rain but are worse today. - She said they would be even worse if she did not keep the sprayers full with the cans throughout the facility. - The flies kept her busy changing the cans in the timed sprayers on the walls throughout the facility. - The cans went into the sprayer units to kill flies, spiders and other bugs. - She kept a full can on her cart to use when a sprayer was out of insecticide. <p>Observation on 6/04/15 at 11:45 a.m. of the 100 Hall revealed:</p> <ul style="list-style-type: none"> - There were 4 metered insecticide spray units attached to the walls at the ceiling level and one at the exit door. - The metered spray units had brown and tan drip marks on the outside covers. <p>Observations on 6/04/15 of the 100 Hall revealed the following:</p> <ul style="list-style-type: none"> - At 11:47 a.m., a resident was swatting at a fly around his face and head with his hands as he stood near the nurse station. - At 12:05 p.m., a resident was walking on the 	D 079	<p>throughout the Facility Once it's done the House Keepers will maintain the sprayers Daily.</p> 	9-30-15
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D 079	<p>Continued From page 5</p> <p>100 Hall directly underneath one of the 4 insecticide spray units in the hallway.</p> <ul style="list-style-type: none"> - At 12:06 p.m. a resident was standing near the insecticide spray unit at the nurses station area. - At 12:10 p.m. an insecticide metered spray unit was observed across from a resident room 119 on the 100 Hall. - At 12:20 p.m. an insecticide metered spray unit was observed on the wall of the activity room at the doorway to the outside smoking area. <p>Interview with a resident in the hall on 6/04/15 at 12:07 p.m. revealed she thought the insecticide spray unit was an air freshener spray and did not know it was was to kill insects.</p> <p>Interview on 6/04/15 at 12:10 p.m. with another resident revealed.</p> <ul style="list-style-type: none"> - The resident did not like the spray units for flies and other insects. - "I do not want it on me!" - It sprays every 15 - 25 minutes day and night. <p>Subsequent interview on 6/05/15 at 2:45 p.m. with the same resident revealed:</p> <ul style="list-style-type: none"> - About 2 months ago the resident asked the housekeeper to remove the can of insecticide in the spray unit on the wall directly across from his room. - When the unit sprayed the fog of the insecticide, it went half way across the hall. - His concern was that if it killed insects, what was it doing to him? - The spray made his skin feel itchy and dry. - He would wash it off briefly. - He had been feeling much better without the spray directly in front of his room. - He could leave the door open now even though it was still spraying in other areas of the hall. - He did not tell anyone but the housekeeper. 	D 079		<p>9-30-15</p>
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D 079	<p>Continued From page 6</p> <p>Observations on 6/04/15 revealed the following:</p> <ul style="list-style-type: none"> - At 12:15 p.m. a metered insecticide spray unit was attached to the wall at the dining room entrance. - At 12:16 p.m. a metered spray unit was attached to the wall near the managers' office and the front entrance area television room. - At 12:28 p.m. a metered spray unit was attached to the wall at the entrance door of the facility. <p>Interview with a resident walking near a metered spray unit by the television room on 6/04/15 at 12:16 p.m. revealed:</p> <ul style="list-style-type: none"> - He said the unit sprayed out about 10 inches to 1 foot into the hallway every so often. - The spray killed the flies. - It did not bother him but there were a lot of flies. <p>Observations on 6/04/15 at 12:18 p.m. of the 200 Hall revealed the following:</p> <ul style="list-style-type: none"> - Three insecticide metered spray units were attached to the walls of the 200 Hall. - An insecticide metered spray unit was observed on the wall near resident rooms 206 and 208 which had open doors. - An insecticide metered spray unit was toward the middle of the hallway on the wall. - An insecticide metered spray unit was attached to the wall near the ceiling at the exit door at the end of the 200 Hall. - Two resident rooms had multiple flies on furniture and beds. <p>Interviews on 6/04/15 at 2:55 p.m. with two residents revealed:</p> <ul style="list-style-type: none"> - One resident said flies are in the bedrooms a lot and they bother her. - They were in the dining room and the 	D 079	<div style="border-left: 1px solid black; border-right: 1px solid black; height: 400px; position: relative;"> <div style="position: absolute; top: 0; right: 0; bottom: 0; left: 0; border: 1px solid black;"></div> </div>	<p style="font-size: 2em; transform: rotate(-90deg);">9-30-15</p>
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D 079	<p>Continued From page 7</p> <p>bedrooms.</p> <ul style="list-style-type: none"> - The other resident agreed they were in the bedrooms. - One resident did not like it when flies went around her head. <p>Interview on 6/04/15 at 1:05 p.m. with the facility Manager revealed:</p> <ul style="list-style-type: none"> - The insecticide metered spray units were used all year round in the facility. - The units have a timer and they usually set it to spray every 30 minutes. - She was not aware of the hazards listed on the cans of insecticide used in the sprayers. - She would have hoped residents would have told her about not liking the sprayers so she could have looked into it. - The Administrator ordered the insecticide cans for the metered spray units. - She was not aware of any residents with skin, respiratory or eye reactions to the spray. - When asked, the facility Manager said she would remove the spray insecticide from the sprayers today. <p>Interview on 6/05/15 at 3:20 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - He had used the insecticide sprayers for 25 years and had never heard of a problem with them. - He was not aware of the hazards listed on the label of the insecticide cans. - He would look into the concern with the health department and the sanitation department. - He does not agree with this, but asked the facility Manager to remove the insecticide cans from the building. <p>Review of the can label on the insecticide used in the metered wall sprayers revealed:</p>	D 079		<p style="text-align: center;">9-30-15</p>
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D 079	<p>Continued From page 8</p> <ul style="list-style-type: none"> - The can label included the contents were to be used as a metered insecticide. - The unit with insecticide was a time released aerosol to be used only in commercial food service areas and preparation areas of milk houses, hospitals, hotels factories, ships and others. <p>Continued review of the label included:</p> <ul style="list-style-type: none"> - "Precautionary Statements" "Hazards to Humans and Domestic Animals." - Cautions included: harmful if swallowed or absorbed through the skin; do not breathe vapors or spray mist and do not get in the eyes or on skin. <p>Further review of the can label included first aide instructions</p> <ul style="list-style-type: none"> - Inhalation - move to fresh air; If not breathing cal 911; Give CPR(cardio-pulmonary resuscitation); call poison control. - Skin/clothing - Take off clothing rinse skin thoroughly with water for 15 -20 minutes; call poison control. - Eyes- Hold eye open and rinse with water slowly for 15-20 minutes. - Swallow- call poison control or medical doctor immediately. <p>Further review revealed, "Restrictions: Do not use in nurseries and rooms where infants were or where ill or aged persons were located.</p> <p>Review of the metered insecticide company's Safety Data Sheet for this product revealed:</p> <ul style="list-style-type: none"> - Under Toxicological Information section, "Medical Condition Aggravated: Excessive exposure will aggravate respiratory cardiovascular or pulmonary illnesses. - Under a section listed as Chronic Health 	D 079		<p>9-30-15</p>

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D 079

Continued From page 9
Hazards: Concentrating vapors and inhaling material can lead to oxygen deprivation, loss of brain function and potential loss of life."

D 079

D 093

10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings

10A NCAC 13F .0306 Housekeeping And Furnishings
(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:
(8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading.
This Rule shall apply to new and existing facilities.

D 093

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to assure 12 of 14 resident rooms had a light overhead of bed with a switch within reach of a resident lying on the bed or a lamp.

The findings are:

Observations on 6/5/15 at 2:24 p.m. in room #104, at 2:24 p.m. in room #110, at 2:26 p.m. in room #112, at 2:26 p.m. in room #114 and at 2:29 p.m. in room #119 revealed there was no lamp or light switch in the resident's room.

Interview with a resident on 6/5/15 at 2:24 p.m. revealed:
-The resident had not had a lamp or overhead switch since the resident had been at the facility (2 years.)
-The resident did not have a problem with not



9-30-15

manager will speak with each resident to see if they would like to have a lamp in there room for reading. And if so manager will consult

10-1-15

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D 093	<p>Continued From page 10</p> <p>having a lamp or a light with a switch overhead of bed.</p> <p>Interview with another resident on 6/5/15 at 2:26 p.m. revealed: -The resident did not have a problem with not having a lamp or a light with a switch overhead of bed. -The resident could not remember how long the resident had not had a lamp or light with a switch overhead of bed.</p> <p>Interview with a third resident on 6/5/15 at 2:29 p.m. revealed: -The resident had plenty of light in the room. -The resident had been living at the facility for two years and never had a lamp in the room. -The resident did not have a problem with not having a lamp or a light overhead of bed.</p> <p>Observation on 6/5/15 at 1:10pm revealed the following rooms had no lamp or light source above the bed: -#204,#205, #207,#209,#210,#211, #212.</p> <p>Two confidential staff interviews revealed: -Staff could not remember a time when residents did have lamps in their rooms. -Every once in a while a family member brought in a lamp. - The resident had been in the facility over a year and had never seen lamps in these rooms. -There used to be lamps at the facility. -Staff did not know what happened to them.</p> <p>Two confidential resident interviews revealed: -There had not been a lamp in residents' rooms since admission. -The resident wanted to read his bible and other magazines but cannot see because of the dim</p>	D 093	<p><i>With the Administrator about getting those lamps in the rooms for the residents. manager will monitor daily to make sure they are working and in good condition</i></p> 	<p><i>10-1-15</i></p>
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D 093	Continued From page 11 light. -The resident wanted to read more but could not see to read at night. Interview with the facility manager on 6/5/15 at 3:00vpm revealed: -There used to be lamps in the resident rooms. -"Some were shaky and were taken out." -She did not know how long some of the residents had not had lamps, "but years." -The owner was aware.	D 093	↓	
{D 150}	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review.	{D 150}	PCA training for the Aide's started May 2015. And ended July 2015 for the Aide's that work on 3rd and 2nd shift, Another class will be set up for the remaining aides that work.	10-1-15 7-21-15

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{D 150}	<p>Continued From page 12</p> <p>This Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to assure that staff who provide or directly supervise staff that provide personal care to residents had successfully completed an 80 hour personal care training and competency evaluation established by the department within six months after hiring for staff hired after September 1, 2003 for 4 of 6 sampled staff. (C, D, E, F).</p> <p>The findings are:</p> <p>A. Review of Staff C's personnel record revealed: -No documentation of personal care (PC) training hours. -The hire date was 8-11-10.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff C was not available for interview.</p> <p>B. Review of Staff D's personnel record revealed: -No documentation of PC training hours. -The hire date was 12/12/10.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff D was not available for interview.</p> <p>C. Review of Staff E's personnel record revealed: -No documentation of PC training hours. -The hire date was 11-1-13.</p>	{D 150}	<p>on the First Shift and Anyone else who needs, the training. in the future when a PCA is hired, the manager will ensure that each person has all the needed requirements for the job or task that they are performing.</p> <p style="text-align: center;">↓</p>	11-26-15
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{D 150}	<p>Continued From page 13</p> <p>Refer to memo in the medication room revealed.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff E was not available for interview.</p> <p>D. Review of Staff F's personnel record revealed: -No documentation of PC training hours. -The hire date was 7-22-13.</p> <p>Interview with Staff F on 6/5/15 at 3:30pm revealed: -There had been no requirement for PC training upon hire. -There had been no training on PC hours since hire but a training was scheduled within the week. -Staff F had provided personal care at other facilities and felt experienced.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <hr/> <p>Review of memo in the medication room revealed: -A mandatory classes for all 2nd and 3rd shift Personal Care Aides (PCA) was scheduled for 6-8-15 from 9am-1pm. -Staff C, D, E, and F were scheduled to take the class.</p> <p>Interview with the facility's Manager on 6/4/15 at 9am revealed: -Staff C, D, E, and F had no PCA training through her facility. -Staff C, D, E, and F had not been required to receive the training within 6 months after hire. -She was aware of the rule area requirement.</p>	{D 150}	<p>Written documentation now in the charts of PCA's. and manager will monitor every two weeks to stay in compliance</p> 	7-9-15
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{D 150}	Continued From page 14 -Three staff had their 80 hours of training as they were Nursing Assistants. -Nine PCA's were currently working at the facility without their personal care hours. -She did not know how to find a provider for the training. -She could not find the resources. -She had talked to various pharmacies and inquired to the required training. -The facility's current pharmacy was contracted to provide the training within the week.	{D 150}	↓	7-21-15
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. THIS IS A TYPE B VIOLATION. Based on observation, interview and record review, the facility failed to assure 5 of 5 sampled residents did not smoke in the facility. (#2, #6, #7, # 8, #9). The findings are: Tour of the facility on 6/04/15 at 8:30 a.m. revealed: - A no smoking sign was at the entrance door. - No smoking signs were on every resident room	{D 270}		

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{D 270}	<p>Continued From page 15</p> <p>door.</p> <ul style="list-style-type: none"> - A smoking policy was not posted. <p>Interview on 6/3/15 at 10:30 a.m. with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - All residents were checked every 1-2 hours. - Residents who smoked were checked at the same times. - If residents were caught smoking, the PCA would tell the Medication Aide (MA). - The PCA had not seen anyone smoking in the facility nor smelled or seen smoke. - There had not been any fires in the facility. <p>Interview on 6/04/15 at 8:35 a.m. with two residents in the facility who were smoking in the outside front smoking area revealed:</p> <ul style="list-style-type: none"> - They both said residents were to smoke only in the outside smoking areas. - There are cans to put butts in. - No fires in the facility and residents participate in fire drills. - Both residents said staff keeps most residents' smoking materials including lighters. - A few residents are allowed to keep their own. <p>Interview on 6/04/15 at 10:15 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - She worked the day shift and cleaned resident rooms, their bathrooms, common baths and other areas. - Residents continued to smoke in bedrooms and bathrooms. - The smoking frequency was better now than a few months ago, but some residents continued to smoke in the building. - She had not seen smoke nor actually observed a resident smoking for 2 months when she had seen and smelled smoke in the hall the Medication Aide (MA) was notified. 	{D 270}	<p>Facility manager has met with all smokers, in the facility. we have discussed the importance of not smoking in the facility. manager along with staff will monitor daily to ensure theres no smoking in the building. each resident was given a policy.</p> 	6-8-15
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{D 270}	<p>Continued From page 16</p> <ul style="list-style-type: none"> - Everyday she found and cleaned up cigarette ashes and butts in bathroom toilets, on the floors and on the beds for Residents #6, #8 and #9 and others. - She had not observed any burn holes on bed linen or on floors. - In the last couple of months the housekeeper had taken smoking evidence found and/or the resident to the Facility Manager, Resident Care Director or the MA. - Management staff would then talk with the resident and decide what to do next. <p>Interview on 6/04/15 at 4:15 p.m. with a PCA revealed:</p> <ul style="list-style-type: none"> - Residents had been known to smoke in the building. - Residents were not allowed to smoke in the facility. - Staff were to check on all residents throughout their shift about every 1-2 hours. - Staff were to report observations of smoking to the MA. - MA and the Facility Manager completed documentation of these incidents. <p>Interview on 6/05/14 at 2:30 p.m. with a MA revealed:</p> <ul style="list-style-type: none"> - Staff were to supervise residents by monitoring every 30 minutes for smoking in the facility and the same for the nonsmokers. - Staff were to document the incidences in the Shift Notes. - The MA said they keep wheelchair residents' smoking materials including lighters. - They give 3-4 cigarettes at a time for a shift. and they can get more later in the day and evening. - Residents who are independent can keep their own smoking materials. 	{D 270}		6-8-15
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{D 270}	<p>Continued From page 17</p> <p>Interview on 6/05/15 at 4:30 p.m. with a PCA revealed:</p> <ul style="list-style-type: none"> - If residents were caught smoking, staff were to tell the resident to stop and then inform the MA or the Facility Manager. - The MA usually wrote the incident in the notes. - The MA kept some residents smoking materials including lighters and then passed them out during the day and evening. - The PCA might give one warning and then tell the MA if they smoked in the facility again on the shift. <p>Interview on 6/05/15 at 6:40 p.m. with the Facility Manager revealed lighters could be confiscated.</p> <p>Interview on 6/05/15 at 6:40 p.m. with a MA revealed residents who smoked usually received 5 cigarettes per shift.</p> <p>1. Review of the FL-2 dated 7/21/14 for Resident #8 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 5/24/13. - Diagnoses included Schizoaffective Disorder, Diabetes Mellitus II and Amputation of the Right Foot. - The FL-2 had disorientation listed as not applicable. - The resident was semi-ambulatory with a wheelchair. <p>Review of Resident #8's Resident Register dated 5/24/13 revealed the resident had a habit of smoking.</p> <p>Review of resident record notes for Resident #8 revealed:</p> <ul style="list-style-type: none"> - A physician note dated 1/14/14 revealed the physician was aware the resident was a smoker. 	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 18</p> <ul style="list-style-type: none"> - There were no other notes found in the resident record related to smoking in the facility. <p>Review of facility shift notes where staff were to document smoking incidents revealed:</p> <ul style="list-style-type: none"> - Shift notes for May 2015 included on 5/20/15 during the 3rd shift, Resident #2 and Resident #8 were in Resident #8's bedroom smoking. - No other information in relation to this incident was included such as counseling and consequences related to the smoking in the facility. <p>Interview on 6/04/15 at 10:15 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - About a month ago she found a small burn mark on the commode seat in the bathroom of Resident #8. - Today she found ashes on the commode tank and on the commode seat in Resident #8's bathroom. <p>Observations on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - In the bathroom of Resident #8, 2 ash smears were on the commode seat and 1 very small burn mark was on the seat - Resident #8 's furniture had burn marks all over the tops of the dresser. <p>Interview on 6/04/15 at 11:45 a.m. with Resident #8 revealed:</p> <ul style="list-style-type: none"> - Residents were not supposed to smoke in the bathrooms or bedrooms. - Residents were to smoke only outside in the designated smoking areas. - The resident had not smoked in the facility since a few months ago. - Staff kept her cigarettes and lighter. 	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 19</p> <ul style="list-style-type: none"> - The resident did not know about the burn marks on the furniture. <p>Interview on 6/05/15 at p.m. with the Manager revealed:</p> <ul style="list-style-type: none"> - She was not aware of this incident although she said read through the shift notes daily. - She did not keep documentation of resident monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>2. Review of the FL-2 for Resident #6 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 7/15/02. - Diagnoses included Schizophrenia, History of Cocaine and Alcohol Abuse. <p>Review of the Resident Register dated 7/15/02 revealed:</p> <ul style="list-style-type: none"> - The resident's memory was adequate. - The resident had a personal habit of smoking. <p>Review of Resident #6's Assessment and Care Plan dated 4/07/15 revealed:</p> <ul style="list-style-type: none"> - The resident was independent with activities of daily living. - There was no information related to the resident smoking. <p>Review of resident record notes for Resident #6 revealed there were no notes found in the resident record related to smoking in the room or bathroom, consequences nor monitoring of the resident's behavior of smoking in the facility.</p>	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 20</p> <p>Observations on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - In the bedroom of Resident #6 there were ashes on the floor on the long side of the bed and ashes and a cigarette butt on the floor at the foot of the bed. <p>Interview on 6/04/15 at 4:15 p.m. a personal care aide revealed:</p> <ul style="list-style-type: none"> - Resident #6 had been known to smoke in the building. - Residents were not allowed to smoke in the facility. - Staff were to check on residents throughout their shift about every 1-2 hours. - Staff were to report observations of smoking to the Medication Aide (MA). - Resident #6 liked to light up in the building prior to going out the door. - The PCA would tell him to put it out and then go out and light up. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>3. Review of facility shift notes for Resident #2 where staff were to document smoking incidents revealed:</p> <ul style="list-style-type: none"> - Shift notes for May 2015 included on 5/20/15 during the 3rd shift, Resident #2 and Resident #8 were in Resident # 8's bedroom smoking. - No other information in relation to this incident was included. <p>Review of resident record notes for Resident #2</p>	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 21</p> <p>revealed there were no other notes found in the resident record related to smoking in the facility or consequences nor monitoring of the resident's behavior of smoking in the facility.</p> <p>Interview on 6/03/15 at 11:45 a.m. with Resident #2 revealed:</p> <ul style="list-style-type: none"> - The resident said smokers were only to use the smoking areas. - No one smoked inside. - She had not smoked in the building in May 2015 nor this month because of fires. - Staff have taken cigarettes and lighters if residents were caught smoking. - She had her smoking materials taken by staff before. <p>Interview on 6/05/15 at 2:10 p.m. with the Facility Manager revealed:</p> <ul style="list-style-type: none"> - She was not aware of this incident. - She would either be told by staff members about incidents of smoking as they happened or she would find out through reading the shift notes daily. - She did not keep documentation of resident behaviors, monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>4. Review of the current FL-2 for Resident #7 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 7/06/94. - Diagnoses included History of Dementia, and Alcohol Abuse. 	{D 270}		6-8-15
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{D 270}	<p>Continued From page 22</p> <ul style="list-style-type: none"> - Under the area of disorientation was "N/A" (non-applicable). <p>Review of the Resident Register for Resident #7 revealed:</p> <ul style="list-style-type: none"> - The resident's memory was adequate. - The resident had a personal habit of smoking. <p>Review of Resident #7's Assessment and Care Plan dated 1/26/15 included:</p> <ul style="list-style-type: none"> - Memory was adequate. - The resident was oriented. - The resident required limited assistance with eating, toileting, bathing, dressing and grooming. - Supervision was need for ambulation and transferring. - There was no documentation related to resident smoking. <p>Review of a physician note dated 4/09/15 revealed the resident had dementia.</p> <p>Review of a form in the resident's record dated and signed on 10/01/03 by Resident #7 included the following:</p> <ul style="list-style-type: none"> - Policies/Procedures at Admissions-Policies for Use of Smoking. - This form included a Fire Plan. - The Fire Plan documentation included: Prevent fires; watch for fires; do not allow trash or rubbish accumulate; observe and enforce smoking regulations; "Smoking in bed is prohibited." <p>Review of resident record notes for Resident #7 revealed there were no other notes found in the resident record related to smoking in the room or bathroom, consequences nor monitoring of the resident's behavior of smoking in the facility.</p> <p>Interveiw on 6/05/15 at 4:30 p.m. with a personal</p>	{D 270}		6-8-15
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{D 270}	<p>Continued From page 23</p> <p>care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - Resident #7 was caught smoking in his room on the evening shift about 1 -2 months ago. - The PCA said she would give a verbal warning the first time on the the shift the resident was caught. - The second time on the shift the resident was caught smoking the PCA would tell the Medication Aide (MA) or the Facility Manager. - Staff were to tell the resident to stop and then inform the (MA) or the Manager. - Residents were to be checked every 30 minutes or more often. - The MA usually wrote the incident in the notes. - The MA kept some residents smoking material and passed them out during the day including lighters. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>5. Review of the current FL-2 for Resident #9 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 4/26/07. - Diagnoses were listed as Tobacco Use, Chronic Obstructive Pulmonary Disease, and Chronic Paranoid Schizophrenia. <p>Review of the Resident Record dated 4/26/15 revealed the resident had a personal habit of smoking.</p> <p>Review of the Resident #9's Assessment and Care Plan dated 12/11/14 revealed:</p> <ul style="list-style-type: none"> - The resident was independent but needed some assistance with eating. - There was no documentation related to resident 	{D 270}		6-8-15
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{D 270}	<p>Continued From page 24</p> <p>smoking.</p> <p>A physician note dated 12/12/14 revealed the resident should cut down on smoking.</p> <p>There were no facility notes or other documentation of smoking nor advising of facility house rules about no smoking in the facility in the resident's record related to smoking since 2/14/13.</p> <p>Interview on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - She found a cigarette butt in the commode of the bathroom of Resident #9 this morning. - She thought the resident got up in the morning and smoked in the bathroom. - She has found evidence of smoking in Resident #9's room often. - She told the Medication Aide (MA) or the facility Manager when it occurred. - The Manager would handle the resident after that. <p>Interview on 6/04/15 at 11:38 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - Resident #9's bedroom and bath had not been cleaned yet because he was asleep directly across from the bathroom in his room. - The cigarette butt in the commode she saw earlier was gone. - She thought the resident got up to the bathroom and probably flushed the butt left in the toilet before she could show the surveyor. <p>Interview on 6/04/15 at 4:00 p.m. with Resident #9 revealed:</p> <ul style="list-style-type: none"> - He knew residents were not to smoke in their rooms, but some did. - He only smoked outside. 	{D 270}		6-8-15
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{D 270}	<p>Continued From page 25</p> <ul style="list-style-type: none"> - At night after the doors were locked at 9 p.m., the semi-enclosed smoking area was available for use. - The resident had smoked 3 or 4 nights ago in his room when he could not sleep. - The resident did not give a reason why he smoked in his room that night. - He knew smoking in his room could cause a fire and did not want a fire in the building. - He was aware, if caught smoking, staff would take his lighter and cigarettes away. - He had them taken away years ago and then he got them back and had not had them taken away for 2 years. - Facility staff took his cigarettes away once a couple of months ago again. - Staff check on residents once in a while on all the shifts but not more than every 1-2 hours. - He did not think he had signed a contract about not smoking in the building. - There was not a smoking policy other than they were not to smoke. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <hr/> <p>Interview on 6/05/15 2:10 p.m. with the Facility Manager revealed:</p> <ul style="list-style-type: none"> - The Facility manager had not been told about any residents still smoking in the facility. - They had tried to stop the smoking in the facility. - "As usual you can not do but so much." - She did not know what else to do to stop the smoking. 	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 26</p> <ul style="list-style-type: none"> - She thought the only thing left was to make their facility a non smoking. - Staff were supposed to supervise residents for smoking by monitoring every 15 minutes. - She did not know staff were not monitoring for smoking every 15 minutes. - There was no place for staff to document the every 15 minute checks. - All rooms were to be checked on all shifts. - There were not any residents on oxygen in the facility now. - Staff were to escort any resident caught smoking in the facility out to the smoking area to smoke and tell them not to smoke in the facility. - Staff were to document in the shift notes or in the resident records when a resident caught smoking. - Staff were to report it to the MA and then the Facility Manger and/or the Resident Care Coordinator would be notified. - The Resident Care Coordinator would then review the smoking policy with the resident caught to ensure they understand. - They do not take away smoking materials but the facility had the right to confiscate smoking materials. - She then said the MA would give residents 4 -5 cigarettes and light the cigarette as needed on each shift. - The facility did not have a policy for discharge if residents continued to smoke in the building. - There had been a history of other consequences but they did not work out. - She did not know staff were not documenting the smoking incidents. - She did not keep documentation of resident behaviors, monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors given. 	{D 270}		6-8-15
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{D 270}	<p>Continued From page 27</p> <p>Review of facility shift notes where staff were to document smoking incidents revealed:</p> <ul style="list-style-type: none"> - There were no shift notes provided for April 2015 after requested. - Shift notes for June 2015 did not reveal any documentation of smoking in the building. <p>Review of the facility's House Rules for Use of Smoking revealed:</p> <ul style="list-style-type: none"> - 1. Residents who smoke must use the designated smoking areas outside of the building. - 2. No smoking is allowed in resident rooms. - 3. Staff will supervise residents who smoke. - The home reserves the rights to confiscate all smoking materials if the resident fails to abide by smoking policies so as to insure fires safety for themselves and other residents. <hr/> <p>Review of the facility's Plan of Protection dated 6/05/15 included:</p> <ul style="list-style-type: none"> - The facility would immediately implement a facility security check list of rooms every 15 minutes with documentation of every resident known to be on the smoking list. - If caught smoking in room, smoking materials will be confiscated. - The facility manager will be notified of infractions of the rule and would come to the facility over the weekend to talk with residents caught smoking. - Staff will give cigarettes or smoking materials in the smoking area. - Staff will stay with smokers until they finish smoking. - The Medication Aide will communicate with Resident Care Coordinator and Facility Manager if someone is caught smoking in the facility. - The Facility manager will check the security 	{D 270}		6-8-15
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{D 270}	Continued From page 28 check logs daily. - Meeting will be set up for all smokers to stress the warning and consequences of smoking in the facility. - The smoking policy will be revised. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2015.	{D 270}	↓	6-8-15
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on observation, interview and record review, the facility failed to contact the primary care physician for 1 of 5 sampled Residents (#4) with blood sugars greater or equal to 350 with 23 of 58 opportunities. The findings are: Review of Resident #4's current FL-2 dated 5/13/15 revealed: -The resident's diagnoses included Type 2 Diabetes Mellitus, diabetic neuropathy and chronic renal insufficiency.	{D 273}	manager Along with the R.C.C. will check 3 times a week Along with the medication Aides to ensure →	

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{D 273}	<p>Continued From page 29</p> <p>-The resident had an order to check blood sugars twice daily.</p> <p>Review of the Resident Register revealed Resident #4 was admitted to the facility on 7/2/98.</p> <p>Resident #4's FL-2 dated 5/13/15 included the following medication orders: -Glipizide 5 milligrams (mg) give twice daily before meals (used to help control blood sugars). -An order for Lantus insulin 100 units (u) give 53 u subcutaneous (sq) at bedtime (long acting insulin used to help control blood sugars). -An order for Novolin R (Regular) Insulin use for sliding scale insulin (short acting insulin) used to help control blood sugars). If blood sugars are between 200 to 239 give 2 u; between 240 to 279 give 4 u; between 280 to 299 give 6 u; between 300 to 349 give 8 u; call the primary care physician if the blood sugars are 350 and give 8 u; if greater than 450 go to the emergency room (ER).</p> <p>Review of Resident #4's April 2015 Medication Administration Record (MAR) revealed: -There was documentation of the above sliding scale with the time, site and units given. -"Lantus 100 u inject 53 u at bedtime sq, increase Lantus 1-2 u at night each day until the morning glucose is stable 100-130" was transcribed on the MAR.</p> <p>Review of Resident #4's 8:00 a.m. (before breakfast) April 2015 blood sugar log revealed: -From 4/8/15-4/30/15, the resident's blood sugars ranged from 191-381. -On 4/10/15 and 4/12/15, the resident refused to have the blood sugars taken. -On 4/15/15, the resident's blood sugar was 355. There was no documentation the resident's</p>	{D 273}	<p>all Blood sugars are documented all Blood sugars that's High report it to the Primary Doctor, if Blood sugars are High 3 consecutive times, contact m.d. and send Resident to the Emergency Room. or as ordered in the m.a.r.</p> <p style="text-align: center;">↓</p>	5-7-15
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{D 273}	<p>Continued From page 30</p> <p>primary care physician was notified. -On 4/20/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's 4:00 p.m. (before supper) April 2015 blood sugar log revealed: -From 4/8/15-4/30/15, the resident's blood sugars ranged from 214-464. -On 4/16/15, the resident refused to have blood sugars taken. -There was no documentation of the blood sugars taken on 4/28/15. -On 4/12/15, the resident's blood sugar was 424. There was no documentation the resident's primary care physician was notified. -On 4/13/15, the resident's blood sugar was 449. There was no documentation the resident's primary care physician was notified. -On 4/14/15, the resident's blood sugar was 472. There was no documentation the resident's primary care physician was notified. -On 4/16/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. -On 4/20/15, the resident's blood sugar was 421. There was no documentation the resident's primary care physician was notified. -On 4/21/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. -On 4/23/15, the resident's blood sugar was 395. There was no documentation the resident's primary care physician was notified. -On 4/25/15, the resident's blood sugar was 360. There was no documentation the resident's primary care physician was notified. -On 4/29/15, the resident's blood sugar was 364. There was no documentation the resident's primary care physician was notified.</p>	{D 273}		6-7-15
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{D 273}	<p>Continued From page 31</p> <p>Review of Resident #4's May 2015 MAR revealed: -There was documentation of the blood sugars from 5/10/15-5/30/15. -There was documentation of the sliding scale with the time, site and units given. -"Lantus 100 u inject 53 u at bedtime sq, increase Lantus 1 u at night each day until the morning glucose is stable 100-130" was transcribed on the MAR.</p> <p>Review of Resident #4's May 2015 blood sugar log revealed: -From 5/1/15-5/19/15, the 8:00 a.m. blood sugars ranged from 153-355. The resident refused to have the blood sugar taken on 5/5/15. -From 5/1/15-5/19/15, the 4:00 p.m. blood sugars ranged from 260-460. The resident refused to have the blood sugar taken on 5/16/15.</p> <p>Review of a facility fax sheet attached to the May 2015 blood sugar log revealed the blood sugars from 5/1/15-5/19/15 was faxed to the primary care physician on 5/20/15.</p> <p>Review of Resident #4's primary care physicians' orders revealed: -An order dated 8/28/14 revealed to give the resident 28 u of Lanutus insulin sq at bedtime. -A subsequent order dated 10/9/14 revealed to give the resident 32 u of Lantus insulin at bedtime. May increase Lantus insulin 1 u nightly until am blood sugar is "around 120-130." -A subsequent order dated 5/12/15 revealed to increase Lantus insulin 1 units at night daily until the am glucose is stable around 120-130. -A current order dated 5/20/15 to increase Lantus insulin to 58 u. Increase Lantus insulin 1 u daily until am glucose "is around 120-130. Please</p>	{D 273}		6-7-15
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{D 273}	<p>Continued From page 32</p> <p>continue on Regular insulin for sliding scale."</p> <p>Review of Resident #4's progress notes dated 5/19/15 revealed:</p> <ul style="list-style-type: none"> -The resident's primary care physician was contacted. -The resident's blood sugars ranged between 300-400. -The resident is up to 55 u of Lantus plus coverage. -The resident refused to go to the emergency room on 5/19/15. <p>Review of Resident #4's 8:00 a.m. May 2015 blood sugar log from 5/20/15-5/31/15 revealed:</p> <ul style="list-style-type: none"> -The blood sugars ranged from 111-429. -On 5/20/15, the resident was out of the facility. -On 5/31/15, the resident refused to have the blood sugars taken. -On 5/21/15, the resident's blood sugar was 365. There was no documentation the resident's primary care physician was notified. -On 5/26/15, the resident's blood sugar was 408. -On 5/29/15, the resident's blood sugar was 429. There was no documentation the resident's primary care physician was notified. <p>Review of Resident #4's 4:00 p.m. May 2015 blood sugar log from 5/20/15-5/31/15 revealed:</p> <ul style="list-style-type: none"> -The blood sugars ranged from 214-464. -On 5/20/15, the resident's blood sugar was 405. There was no documentation the resident's primary care physician was notified. -On 5/21/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. There was no documentation the resident's primary care physician was notified. -On 5/22/15, the resident's blood sugar was 372. There was no documentation the resident's 	{D 273}		6-7-15-
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{D 273}	<p>Continued From page 33</p> <p>primary care physician was notified. -On 5/23/15, the resident's blood sugar was 464. The blood sugar was rechecked at 8 p.m. and was 324. There was no documentation if the resident's primary care physician was notified or if the resident was sent to the ER. - On 5/27/15, the resident's blood sugar was 413. There was no documentation the resident's primary care physician was notified. -On 5/28/15, the resident's blood sugar was 454. There was no documentation the resident's primary care physician was notified or if the resident was sent to the ER. -On 5/30/15, the resident's blood sugar was 404. There was no documentation the resident's primary care physician was notified. -On 5/31/15, the resident's blood sugar was 354. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's progress note entry dated 5/26/15 at 5:00 p.m. documented by staff revealed: -The resident's primary care physician revealed to give the resident 59 u of Lantus insulin on 5/26/15 and increase 1 u of Lantus insulin nightly until the resident's glucose is between 120-130 in the am. -If the resident received up to 100 u of Lantus, it would be fine, because the physician was trying to find a dose of Lantus insulin, which would work for the resident. -Notify the physician if there are any changes in the blood sugars. -If the resident received up to 100 u of Lantus insulin it would be fine. The physician was trying to find a night dose of Lantus, which is why he requested the facility to increase the insulin 1 u each night until blood sugars ranged from 120-130.</p>	{D 273}		6-7-15
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{D 273}	<p>Continued From page 34</p> <p>Review of Resident #4's June 2015 MAR revealed: -There was documentation of the sliding scale with the time, site and units given. -"Lantus 100 u inject 58 u at bedtime sq, increase Lantus 1 u at night each day until the morning glucose is stable 120-130" was transcribed on the MAR.</p> <p>Review of Resident #4's 8:00 a.m. June 2015 blood sugar log from 6/1/15-6/3/15 revealed: -The resident refused to have the blood sugars taken on 6/1/15. -On 6/2/15, the resident's blood sugar was 300. -On 6/3/15, the resident's blood sugar was 373. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's 4:00 p.m. June 2015 blood sugar log from 6/1/15-6/2/15 revealed: -On 6/1/15, the resident's blood sugar was 331. -On 6/2/15, the resident's blood sugar was 360. The resident's primary care physician was notified.</p> <p>Interview with a Medication Aide (MA) on 6/3/15 at 10:45 a.m. revealed: -Resident #4 had an order to contact the primary care physician if the sugar is 350 and to give 8 u of insulin. If the blood sugar is 450 and above to give 8 u of insulin and send to the ER. -The Lantus insulin is increased 1 u nightly if the a.m. blood sugars are not between a certain range. -Resident #4's blood sugars are 350 and above 3-4 days weekly. -Sometimes Resident #4 refused to go to the ER or physician's office. The physician just said to monitor the blood sugars. -The MA had not always contacted the Resident</p>	{D 273}		6-7-15
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{D 273}	<p>Continued From page 35</p> <p>#4's primary care physician when the blood sugars were 350 and above or sent the resident to the ER when the blood sugars were 450 and above.</p> <p>-On 5/27/15, Resident #4's a.m. blood sugar was 368. He gave the resident 8 u of insulin.</p> <p>-He rechecked the resident's blood sugar 15 minutes later and contacted the physician.</p> <p>-He could not provide documentation of contacting the physician.</p> <p>Interview with another MA on 6/5/15 at 3:15 p.m. revealed:</p> <p>-When Resident #4's blood sugars were 350 and above or 450 and above, he did not contact the resident's physician.</p> <p>-He should have contacted Resident #4's physician when the blood sugars were out of range.</p> <p>-There was no excuse to why he did not contact Resident #4's physician.</p> <p>Interview with the Resident Care Coordinator (RCC) on 6/5/15 at 2:47 p.m. revealed:</p> <p>-The RCC supervised the MAs</p> <p>-The MA should fax the physician when needed.</p> <p>-Weekdays, the MA will inform the RCC when they have faxed the resident's physician.</p> <p>-Resident #4's primary care physician responded better via fax.</p> <p>-She did not check blood sugar logs to make sure the MA's contacted the physician when the blood sugars were in a certain range.</p> <p>-She only checked the fax to make sure it was received by the resident's primary care physician.</p> <p>Interview with the facility Manager on 6/5/15 at 4:00 p.m. revealed:</p> <p>-The MA and RCC should contact Resident #4's primary care physician when the blood sugars are</p>	{D 273}		<p>6-7-15</p>
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√{D 273}	Continued From page 36 out of range. -If the RCC or MA cannot fax the resident's physician, inform the Manager and she would try to fax the resident's physician. -The RCC should check the blood sugar logs three times weekly to make sure MA's are contacting the resident's primary care physicians when needed. -She was not aware the RCC had not been checking the blood sugar logs to make sure staff are contacting the resident's physician as ordered. -She was notified on 6/5/15 Resident #4's primary care physician would no longer be working at the company. Resident #4 had to come to the care provider's office to be re-evaluated by another physician. Resident #4's primary care physician could not be reached by the end of the survey. The Administrator was not available for interview.	{D 273}	↓	6-7-15
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D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by:	D 287	manager has spoken with Dietary supervisor pertaining to the place setting at all meal times Dietary supervisor assured the manager	6-20-15
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D 287	<p>Continued From page 37</p> <p>Based on observation, interview and record review, the facility failed to assure residents received a place setting (knife, fork, spoon) at every meal.</p> <p>The findings are:</p> <p>Interview with three residents on 6/2/15 between 10:56 a.m. and 11:39 p.m. revealed:</p> <ul style="list-style-type: none"> -Residents received either a spoon or fork during the meals. -Residents did not receive a spoon, fork and knife with each meal. -The residents did not have a problem with only receiving a spoon or a fork. -The residents could not remember the last time they received a knife with the meals. <p>Interview with a fourth resident on 6/2/15 at 11:45 a.m. revealed:</p> <ul style="list-style-type: none"> -The resident received either a spoon or fork during the meals. -The resident did not receive a knife with each meal. -"It's tough trying to cut a piece of meat with a spoon." -The resident had not complained to anyone. -The resident could not remember the last time they received a spoon, knife and fork with the meals. <p>Observation of the lunch meal in the dining room on 6/2/15 at 12:11 p.m. revealed the all of the residents received place setting, which included a spoon, fork and knife with the meal.</p> <p>Interview with a fifth resident on 6/2/15 at 3:11 p.m. revealed:</p> <ul style="list-style-type: none"> -"We get a knife, fork and spoon most days." -"We usually get one or the other." 	D 287	<p><i>that these items are being put out, manager's monitoring place settings at all meals, with the exception of supertime, that will be monitored by supervisor's that are on duty in the evenings. this will be monitored daily.</i></p> 	6-30-15
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D 287	<p>Continued From page 38</p> <ul style="list-style-type: none"> -If the resident requested a knife, staff would give the resident a knife. -For breakfast on 6/2/15, the residents received a fork for breakfast. The resident did not have a problem with only receiving a fork for breakfast. -The resident could not remember the last time they received a spoon, knife and fork with the meals. <p>Interview with a sixth resident on 6/5/15 at 2:31 p.m. revealed:</p> <ul style="list-style-type: none"> -The residents usually received a fork with the meals. -The resident had to cut the meat with a fork. -"Sometimes they don't have a knife." -The resident could not remember the last time they received a spoon, knife and fork with the meals. <p>Interview with two other residents between 6/2/15-6/5/15 (time unknown) revealed:</p> <ul style="list-style-type: none"> -The residents had received a spoon, knife and fork for the first time in a long time. -The residents could not remember the last time they received a spoon, knife and fork. <p>Observation of the dinner meal on 6/2/15 at 5:02 p.m. revealed all of the residents (20) in the dining room received a place setting, which included a spoon, fork and knife during the meal.</p> <p>Observation of the breakfast meal on 6/3/15 at 8:06 a.m. revealed all of the residents (36) in the dining room received place setting, which included a spoon, fork and knife during the meal.</p> <p>Interview with two staff, who served meals to the resident, on 6/3/15 at 11:51 a.m. revealed:</p> <ul style="list-style-type: none"> -The residents always received a knife, fork and spoon with the meals. 	D 287		<p>6-20-15</p>
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D 287	<p>Continued From page 39</p> <p>-No residents had ever complained on not receiving a knife, fork and spoon with meals.</p> <p>Interview with the Cook on 6/3/15 at 11:55 a.m. revealed: -Every meal the residents received a spoon, fork and knife. -The Cook was responsible for setting the table, which included placing the spoon, fork and knife on the table. -No residents had ever complained on not receiving a spoon, fork and knife at every meal. -The residents had received the place settings at least since January 2015.</p> <p>Interview with the Dietary Supervisor on 6/3/15 at 12:01 p.m. revealed: -At every meal, dietary set the table which included putting a place setting on the table for the residents. -The place setting included a spoon, fork and knife for the residents. -For the past six years, the residents had received a place setting at every meal. -No residents had complained of not receiving a spoon, fork and knife at every meals.</p> <p>Observation of the lunch meal on 6/3/15 at 12:03 p.m. revealed all of the residents (33) in the dining room received a place setting, which included a spoon, fork and knife during the meal.</p> <p>Interview with the Resident Care Coordinator on 6/5/15 at 2:47 p.m. revealed: -The facility Manager was responsible for dietary. -She does not check the dining room to make sure residents received a spoon, fork and knife during meals.</p> <p>Interview with the facility Manager on 6/5/15 at</p>	D 287		6-26-15
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D 287	Continued From page 40 4:00 p.m. revealed: -She was responsible for dietary. -The residents may have only a spoon and fork with the meals. Some of the residents may not receive a knife with a meal, because of the resident's mental health diagnoses. She could not provide names of resident who should not receive a knife. -Sometimes the residents may only receive a spoon, because the meal only require the use of a spoon. -She was unsure if the residents received a knife with the meals. -She was aware the residents should receive a spoon, fork and knife at every meal. The Administrator was not available for interview.	D 287	↓	6-30-15
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, were maintained and exercised without hindrance. The findings are: Cross refer to Tag D911, G.S. 131D-21(1) Declaration of Residents' Rights.	{D 338}	manager will monitor and Assure All residents have a Blind to there Window for Privacy And staff along with manager →	9-16-15

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{D 338}	Continued From page 41 Based on observation and interview, the facility failed to assure 2 of 2 residents were treated with respect, consideration, dignity and full recognition of individuality and right to privacy by not providing curtains, draperies or blinds in a shared room.	{D 338}	Will Check All room daily to Ensure each room has Privacy.	
{D911}	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION</p> <p>The Type B Violation was abated. Non-compliance continues.</p> <p>Based on observation and interview, the facility failed to assure 2 of 2 residents were treated with respect, consideration, dignity and full recognition of individuality and right to privacy by not providing curtains, draperies or blinds in a shared room.</p> <p>The findings are:</p> <p>Observation of room #205 on 6/5/15 1:15pm revealed no curtains or blinds covering the large window of the room.</p> <p>One confidential resident interview revealed: -There had not been blinds in room #205 as long as this staff could remember.</p>	{D911}		9-16-15

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{D911}	<p>Continued From page 42</p> <p>One confidential staff interview revealed: -There had been blinds a month ago in room #205. -Every time someone put up new blinds the resident would grab the blinds by the cord or jerk the blinds anyway possible. -Staff were afraid the blinds being pulled down like that would possibly hurt the 2 residents in the room. -Staff had mentioned this to management. -Staff was told there was no use putting up blinds because the resident would pull them down. -The resident that pulled the blinds down required changing of incontinent pads.</p> <p>Interview with the facility manager on 6/5/15 at 6:15pm revealed: -There had been 6 sets of blinds put up in room #205. -The resident will snatch the blinds down anyway he can. -She had mentioned to the maintenance man about some way to secure the pull cords of the blinds. -The maintenance man was very busy. -She did not believe the owner was aware of the missing blinds.</p> <p>The maintenance man could not be reached by the end of the survey.</p> <p>The Administrator was not available for interview.</p>	{D911}		<p>9-16-15</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</p>	{D912}		

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{D912}	<p>Continued From page 43</p> <p>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 review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to residents smoking inside the facility.</p> <p>The findings are:</p> <p>Based on observation, interview and record review, the facility failed to assure 5 of 5 sampled residents did not smoke in the facility. (# 2, #6, # 7, # 8, # 9). [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type B Violation)]</p>	{D912}	<p>refer to - smoking policy.</p> 	6-8-15
{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</p>	{D992}		

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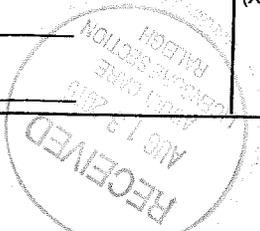
{D992}	<p>Continued From page 44</p> <p>screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance 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: Based on interviews and record reviews, the facility failed to require an examination and screening for the presence of controlled substances required for applicants for employment in adult care homes for 3 of 3 sampled staff. (B, E, G).</p> <p>The findings are:</p> <p>A. Review of Staff B's personnel record revealed: -The hire date was 4/15/15. -No documentation of a drug screen.</p> <p>Interview with Staff B on 6/5/15 at 12:55pm revealed: -No drug screen was required upon hire. -She could not recall if she had been told a drug screen would be required in the future.</p>	{D992}	<p>The owner is working with a company, so that a drug screen will be done on all new staff, that →</p>	<p>06-05-15 91-266</p>
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{D992}	<p>Continued From page 45</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>B. Review of Staff E's personnel record revealed: -The hire date was 11/1/13. -No documentation of a drug screen.</p> <p>Staff E was not available for interview.</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>C. Review of Staff G's personnel record revealed: -The hire date was 5/11/15. -No documentation of a drug screen.</p> <p>Staff G was not available for interview.</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>Interview with the facility Manager on 6/5/15 at 12:55am revealed: -The facility did not require drug screens upon hire. -The owner had communicated he was going to contract a company to provide that service but nothing had been done about it. -She was aware of the rule requirement. -The owner was aware of the rule requirement from the last survey.</p> <p>The Administrator was not available for interview.</p>	{D992}	<p>have been Hired, as soon AS this process is complete all drug screen will be done, AS needed</p>	<p>9-22-15</p>

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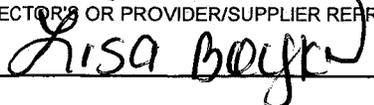
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 2-5, 2015.	{D 000}		
{D 072}	<p>10A NCAC 13F .0305(m) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure the outside grounds of the facility were maintained in a clean and safe condition.</p> <p>The findings are:</p> <p>Observation on 6/5/15 at 4:20pm revealed:</p> <ul style="list-style-type: none"> - The back side of the building had faded white and black paint on the walls. - The front left side of the building had a ladder and a large paint can on the ground. - The storage shed was covered in peeling paint. - Two very large facility signs were leaned against the right side of the shed. - Two of the four sign posts, on this sign had concrete chunks attached where they had been imbedded in the ground. - A large stack of white plastic water pipes and black drainage pipes were piled up next to the 	{D 072}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE manager	(X6) DATE 8-10-15
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{D 072}	<p>Continued From page 1</p> <p>shed on the left side.</p> <p>Observation on 6/5/15 at 4:20pm revealed there were still multiple items sitting outside the storage building in the back yard of the building such as a rusty bedframe, 6 mattresses, a recliner with ripped upholstery, Geri-chair, bedside commode, bedside dresser, and multiple stacks of bricks.</p> <p>Observation on 6/2/15 at 4:25pm revealed:</p> <ul style="list-style-type: none"> -There was a brick area on the outside smoking courtyard next to the activity room. -The ground was exposed where an area 5 by 5 feet of missing bricks presented a trip hazard. -Multiple smokers walked in and out of the smoking area. -The ground underneath some of the bricks was uneven. <p>Observation on 6/5/15 at 6:10pm revealed:</p> <ul style="list-style-type: none"> -The brick patio smoking area still contained missing bricks and an uneven terrain. <p>Two confidential staff interviews revealed:</p> <ul style="list-style-type: none"> -Staff did not believe the items around the facility's storage shed presented a safety concern for the residents. -There used to be more items around the shed and the facility's maintenance man had removed them. <p>Interview with a resident on 6/2/15 at 10:56 am revealed the resident had no problems with the outside premise.</p> <p>Interview with a second resident on 6/2/15 at 11:19am revealed the resident had no problems with the outside cleanliness of the facility.</p> <p>Interview with a third resident on 6/2/15 at 11:45am revealed:</p>	{D 072}		

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{D 072}	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The outside of the building was clean. -The yard had been mowed 3-4 days ago. <p>Interview with a fourth resident on 6/2/15 at 3pm revealed the resident was unsure how often the outside of the building was cleaned.</p> <p>Interview with the facility Manager on 6/5/15 at 6:15pm revealed:</p> <ul style="list-style-type: none"> -She was aware there were still items around the facility's storage shed. -There were only certain days the dump was open to discard items around the storage shed. -The owner had told staff he had plans to get rid of the items around the facility's storage shed but had not told staff in what time frame. -No residents had tripped or gotten hurt because of the missing bricks. -She had talked with the maintenance man about removing the bricks and starting all over to redesign this area as a patio. -She did not know when the remodeling was going to start. -The maintenance man was very busy as he has to cover 2 facilities. -The maintenance man was not available for an interview. <p>The Maintenance man could not be reached by the end of the survey.</p> <p>The Administrator was not available for interview.</p>	{D 072}		7-20-15
{D 074}	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall:</p>	{D 074}	<p>Manager will monitor outside grounds 3x weekly</p>	

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{D 074} Continued From page 3
(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;

This Rule is not met as evidenced by:
Non-compliance continues

D 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings

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.

This Rule is not met as evidenced by:
Based on observation and interview, the facility failed to assure the facility did not use hazardous insecticide sprays inside of the facility. The findings are:

Observations of resident room 106 on 6/03/15 at 11:45 a.m. revealed:
- Multiple flies in a resident's room.
- Several flies were crawling around on the bed.
- Four flies were moving around on the top of the dresser.
- Two flies were on the side table near the window.
- Three flies were on the window sill.

Interview on 6/03/15 at 11:45 a.m. with two residents in the room revealed:

{D 074}

D 079

To Ensure It's free from hazardous material, and report to the maintenance Department for removal, Also House Keeping will help. 3 times a week

9-10-15



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D 079	<p>Continued From page 4</p> <ul style="list-style-type: none"> - There were flies off and on in rooms lately. - They were bothersome at times but were not so bad today. <p>Observation on 6/04/15 at 11:30 p.m. of three resident rooms on the 100 Hall revealed each room had two - five flies on the furniture and two - three flies on the beds.</p> <p>Interview on 6/04/15 at 11:35 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - There were many flies in the facility at different times of the year. - They were better yesterday with the rain but are worse today. - She said they would be even worse if she did not keep the sprayers full with the cans throughout the facility. - The flies kept her busy changing the cans in the timed sprayers on the walls throughout the facility. - The cans went into the sprayer units to kill flies, spiders and other bugs. - She kept a full can on her cart to use when a sprayer was out of insecticide. <p>Observation on 6/04/15 at 11:45 a.m. of the 100 Hall revealed:</p> <ul style="list-style-type: none"> - There were 4 metered insecticide spray units attached to the walls at the ceiling level and one at the exit door. - The metered spray units had brown and tan drip marks on the outside covers. <p>Observations on 6/04/15 of the 100 Hall revealed the following:</p> <ul style="list-style-type: none"> - At 11:47 a.m., a resident was swatting at a fly around his face and head with his hands as he stood near the nurse station. - At 12:05 p.m., a resident was walking on the 	D 079		

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D 079	<p>Continued From page 5</p> <p>100 Hall directly underneath one of the 4 insecticide spray units in the hallway.</p> <ul style="list-style-type: none"> - At 12:06 p.m. a resident was standing near the insecticide spray unit at the nurses station area. - At 12:10 p.m. an insecticide metered spray unit was observed across from a resident room 119 on the 100 Hall. - At 12:20 p.m. an insecticide metered spray unit was observed on the wall of the activity room at the doorway to the outside smoking area. <p>Interview with a resident in the hall on 6/04/15 at 12:07 p.m. revealed she thought the insecticide spray unit was an air freshener spray and did not know it was was to kill insects.</p> <p>Interview on 6/04/15 at 12:10 p.m. with another resident revealed.</p> <ul style="list-style-type: none"> - The resident did not like the spray units for flies and other insects. - "I do not want it on me!" - It sprays every 15 - 25 minutes day and night. <p>Subsequent interview on 6/05/15 at 2:45 p.m. with the same resident revealed:</p> <ul style="list-style-type: none"> - About 2 months ago the resident asked the housekeeper to remove the can of insecticide in the spray unit on the wall directly across from his room. - When the unit sprayed the fog of the insecticide, it went half way across the hall. - His concern was that if it killed insects, what was it doing to him? - The spray made his skin feel itchy and dry. - He would wash it off briefly. - He had been feeling much better without the spray directly in front of his room. - He could leave the door open now even though it was still spraying in other areas of the hall. - He did not tell anyone but the housekeeper. 	D 079		

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D 079	<p>Continued From page 6</p> <p>Observations on 6/04/15 revealed the following:</p> <ul style="list-style-type: none"> - At 12:15 p.m. a metered insecticide spray unit was attached to the wall at the dining room entrance. - At 12:16 p.m. a metered spray unit was attached to the wall near the managers' office and the front entrance area television room. - At 12:28 p.m. a metered spray unit was attached to the wall at the entrance door of the facility. <p>Interview with a resident walking near a metered spray unit by the television room on 6/04/15 at 12:16 p.m. revealed:</p> <ul style="list-style-type: none"> - He said the unit sprayed out about 10 inches to 1 foot into the hallway every so often. - The spray killed the flies. - It did not bother him but there were a lot of flies. <p>Observations on 6/04/15 at 12:18 p.m. of the 200 Hall revealed the following:</p> <ul style="list-style-type: none"> - Three insecticide metered spray units were attached to the walls of the 200 Hall. - An insecticide metered spray unit was observed on the wall near resident rooms 206 and 208 which had open doors. - An insecticide metered spray unit was toward the middle of the hallway on the wall. - An insecticide metered spray unit was attached to the wall near the ceiling at the exit door at the end of the 200 Hall. - Two resident rooms had multiple flies on furniture and beds. <p>Interviews on 6/04/15 at 2:55 p.m. with two residents revealed:</p> <ul style="list-style-type: none"> - One resident said flies are in the bedrooms a lot and they bother her. - They were in the dining room and the 	D 079		
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D 079	<p>Continued From page 7</p> <p>bedrooms.</p> <ul style="list-style-type: none"> - The other resident agreed they were in the bedrooms. - One resident did not like it when flies went around her head. <p>Interview on 6/04/15 at 1:05 p.m. with the facility Manager revealed:</p> <ul style="list-style-type: none"> - The insecticide metered spray units were used all year round in the facility. - The units have a timer and they usually set it to spray every 30 minutes. - She was not aware of the hazards listed on the cans of insecticide used in the sprayers. - She would have hoped residents would have told her about not liking the sprayers so she could have looked into it. - The Administrator ordered the insecticide cans for the metered spray units. - She was not aware of any residents with skin, respiratory or eye reactions to the spray. - When asked, the facility Manager said she would remove the spray insecticide from the sprayers today. <p>Interview on 6/05/15 at 3:20 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - He had used the insecticide sprayers for 25 years and had never heard of a problem with them. - He was not aware of the hazards listed on the label of the insecticide cans. - He would look into the concern with the health department and the sanitation department. - He does not agree with this, but asked the facility Manager to remove the insecticide cans from the building. <p>Review of the can label on the insecticide used in the metered wall sprayers revealed:</p>	D 079		
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D 079	<p>Continued From page 8</p> <ul style="list-style-type: none"> - The can label included the contents were to be used as a metered insecticide. - The unit with insecticide was a time released aerosol to be used only in commercial food service areas and preparation areas of milk houses, hospitals, hotels factories, ships and others. <p>Continued review of the label included:</p> <ul style="list-style-type: none"> - "Precautionary Statements" "Hazards to Humans and Domestic Animals." - Cautions included: harmful if swallowed or absorbed through the skin; do not breathe vapors or spray mist and do not get in the eyes or on skin. <p>Further review of the can label included first aide instructions</p> <ul style="list-style-type: none"> - Inhalation - move to fresh air; If not breathing cal 911; Give CPR(cardio-pulmonary resuscitation); call poison control. - Skin/clothing - Take off clothing rinse skin thoroughly with water for 15 -20 minutes; call poison control. - Eyes- Hold eye open and rinse with water slowly for 15-20 minutes. - Swallow- call poison control or medical doctor immediately. <p>Further review revealed, "Restrictions: Do not use in nurseries and rooms where infants were or where ill or aged persons were located.</p> <p>Review of the metered insecticide company's Safety Data Sheet for this product revealed:</p> <ul style="list-style-type: none"> - Under Toxicological Information section, "Medical Condition Aggravated: Excessive exposure will aggravate respiratory cardiovascular or pulmonary illnesses. - Under a section listed as Chronic Health 	D 079		

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D 079	Continued From page 9 Hazards: Concentrating vapors and inhaling material can lead to oxygen deprivation, loss of brain function and potential loss of life."	D 079		
D 093	<p>10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading. This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure 12 of 14 resident rooms had a light overhead of bed with a switch within reach of a resident lying on the bed or a lamp.</p> <p>The findings are:</p> <p>Observations on 6/5/15 at 2:24 p.m. in room #104, at 2:24 p.m. in room #110, at 2:26 p.m. in room #112, at 2:26 p.m. in room #114 and at 2:29 p.m. in room #119 revealed there was no lamp or light switch in the resident's room.</p> <p>Interview with a resident on 6/5/15 at 2:24 p.m. revealed: -The resident had not had a lamp or overhead switch since the resident had been at the facility (2 years.) -The resident did not have a problem with not</p>	D 093		

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D 093	<p>Continued From page 10</p> <p>having a lamp or a light with a switch overhead of bed.</p> <p>Interview with another resident on 6/5/15 at 2:26 p.m. revealed:</p> <ul style="list-style-type: none"> -The resident did not have a problem with not having a lamp or a light with a switch overhead of bed. -The resident could not remember how long the resident had not had a lamp or light with a switch overhead of bed. <p>Interview with a third resident on 6/5/15 at 2:29 p.m. revealed:</p> <ul style="list-style-type: none"> -The resident had plenty of light in the room. -The resident had been living at the facility for two years and never had a lamp in the room. -The resident did not have a problem with not having a lamp or a light overhead of bed. <p>Observation on 6/5/15 at 1:10pm revealed the following rooms had no lamp or light source above the bed: -#204,#205, #207,#209,#210,#211, #212.</p> <p>Two confidential staff interviews revealed:</p> <ul style="list-style-type: none"> -Staff could not remember a time when residents did have lamps in their rooms. -Every once in a while a family member brought in a lamp. - The resident had been in the facility over a year and had never seen lamps in these rooms. -There used to be lamps at the facility. -Staff did not know what happened to them. <p>Two confidential resident interviews revealed:</p> <ul style="list-style-type: none"> -There had not been a lamp in residents' rooms since admission. -The resident wanted to read his bible and other magazines but cannot see because of the dim 	D 093		
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{D 150}	<p>Continued From page 12</p> <p>This Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to assure that staff who provide or directly supervise staff that provide personal care to residents had successfully completed an 80 hour personal care training and competency evaluation established by the department within six months after hiring for staff hired after September 1, 2003 for 4 of 6 sampled staff. (C, D, E, F).</p> <p>The findings are:</p> <p>A. Review of Staff C's personnel record revealed: -No documentation of personal care (PC) training hours. -The hire date was 8-11-10.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff C was not available for interview.</p> <p>B. Review of Staff D's personnel record revealed: -No documentation of PC training hours. -The hire date was 12/12/10.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff D was not available for interview.</p> <p>C. Review of Staff E's personnel record revealed: -No documentation of PC training hours. -The hire date was 11-1-13.</p>	{D 150}	<p>through the local Technical College. but since then we have found someone that will give the class to the staff one class has already been completed, and the other class will start the second week in September. Each time a new staff member is hired the manager will be responsible for seeing that it's followed through.</p> <p style="text-align: center;">↓</p>	6-21-15
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{D 150}	<p>Continued From page 13</p> <p>Refer to memo in the medication room revealed.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff E was not available for interview.</p> <p>D. Review of Staff F's personnel record revealed: -No documentation of PC training hours. -The hire date was 7-22-13.</p> <p>Interview with Staff F on 6/5/15 at 3:30pm revealed: -There had been no requirement for PC training upon hire. -There had been no training on PC hours since hire but a training was scheduled within the week. -Staff F had provided personal care at other facilities and felt experienced.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Review of memo in the medication room revealed: -A mandatory classes for all 2nd and 3rd shift Personal Care Aides (PCA) was scheduled for 6-8-15 from 9am-1pm. -Staff C, D, E, and F were scheduled to take the class.</p> <p>Interview with the facility's Manager on 6/4/15 at 9am revealed: -Staff C, D,E, and F had no PCA training through her facility. -Staff C, D, E, and F had not been required to receive the training within 6 months after hire. -She was aware of the rule area requirement.</p>	{D 150}		6-21-15
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{D 150} Continued From page 14
 -Three staff had their 80 hours of training as they were Nursing Assistants.
 -Nine PCA's were currently working at the facility without their personal care hours.
 -She did not know how to find a provider for the training.
 -She could not find the resources.
 -She had talked to various pharmacies and inquired to the required training.
 -The facility's current pharmacy was contracted to provide the training within the week.

{D 150}

{D 270} 10A NCAC 13F .0901(b) Personal Care and Supervision

 10A NCAC 13F .0901 Personal Care and Supervision
 (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

{D 270}

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A2 VIOLATION

The Type A2 Violation is abated.

THIS IS A TYPE B VIOLATION.

Based on observation, interview and record review, the facility failed to assure 5 of 5 sampled residents did not smoke in the facility. (#2, #6, #7, #8, #9). The findings are:

Tour of the facility on 6/04/15 at 8:30 a.m. revealed:

- A no smoking sign was at the entrance door.
- No smoking signs were on every resident room



6-21-15.

Smoking Policy has been giving to All Residents that smoke, by the R.CC Along with the manager

6-8-15

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{D 270}	<p>Continued From page 15</p> <p>door.</p> <ul style="list-style-type: none"> - A smoking policy was not posted. <p>Interview on 6/3/15 at 10:30 a.m. with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - All residents were checked every 1-2 hours. - Residents who smoked were checked at the same times. - If residents were caught smoking, the PCA would tell the Medication Aide (MA). - The PCA had not seen anyone smoking in the facility nor smelled or seen smoke. - There had not been any fires in the facility. <p>Interview on 6/04/15 at 8:35 a.m. with two residents in the facility who were smoking in the outside front smoking area revealed:</p> <ul style="list-style-type: none"> - They both said residents were to smoke only in the outside smoking areas. - There are cans to put butts in. - No fires in the facility and residents participate in fire drills. - Both residents said staff keeps most residents' smoking materials including lighters. - A few residents are allowed to keep their own. <p>Interview on 6/04/15 at 10:15 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - She worked the day shift and cleaned resident rooms, their bathrooms, common baths and other areas. - Residents continued to smoke in bedrooms and bathrooms. - The smoking frequency was better now than a few months ago, but some residents continued to smoke in the building. - She had not seen smoke nor actually observed a resident smoking for 2 months when she had seen and smelled smoke in the hall the Medication Aide (MA) was notified. 	{D 270}	<p>And they were Read one by one to the Resident's and they were Signed, and put in there chart, and one giving to them to have on hand. Since then more NO smoking signs have been put up throughout the Facility. Resident's are monitor by R.C.C, manager, and staff to ensure there's no smoking in the facility</p>	6-8-15
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{D 270}	<p>Continued From page 16</p> <ul style="list-style-type: none"> - Everyday she found and cleaned up cigarette ashes and butts in bathroom toilets, on the floors and on the beds for Residents #6, #8 and #9 and others. - She had not observed any burn holes on bed linen or on floors. - In the last couple of months the housekeeper had taken smoking evidence found and/or the resident to the Facility Manager, Resident Care Director or the MA. - Management staff would then talk with the resident and decide what to do next. <p>Interview on 6/04/15 at 4:15 p.m. with a PCA revealed:</p> <ul style="list-style-type: none"> - Residents had been known to smoke in the building. - Residents were not allowed to smoke in the facility. - Staff were to check on all residents throughout their shift about every 1-2 hours. - Staff were to report observations of smoking to the MA. - MA and the Facility Manager completed documentation of these incidents. <p>Interview on 6/05/14 at 2:30 p.m. with a MA revealed:</p> <ul style="list-style-type: none"> - Staff were to supervise residents by monitoring every 30 minutes for smoking in the facility and the same for the nonsmokers. - Staff were to document the incidences in the Shift Notes. - The MA said they keep wheelchair residents' smoking materials including lighters. - They give 3-4 cigarettes at a time for a shift. and they can get more later in the day and evening. - Residents who are independent can keep their own smoking materials. 	{D 270}	<p>Residents are checked ever 30min. If a resident violate's the policy there smoking material will be taken and demonitor by staff only. Everyday of the week.</p> 	<p>5/2/15</p>
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{D 270}	<p>Continued From page 17</p> <p>Interview on 6/05/15 at 4:30 p.m. with a PCA revealed:</p> <ul style="list-style-type: none"> - If residents were caught smoking, staff were to tell the resident to stop and then inform the MA or the Facility Manager. - The MA usually wrote the incident in the notes. - The MA kept some residents smoking materials including lighters and then passed them out during the day and evening. - The PCA might give one warning and then tell the MA if they smoked in the facility again on the shift. <p>Interview on 6/05/15 at 6:40 p.m. with the Facility Manager revealed lighters could be confiscated.</p> <p>Interview on 6/05/15 at 6:40 p.m. with a MA revealed residents who smoked usually received 5 cigarettes per shift.</p> <p>1. Review of the FL-2 dated 7/21/14 for Resident #8 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 5/24/13. - Diagnoses included Schizoaffective Disorder, Diabetes Mellitus II and Amputation of the Right Foot. - The FL-2 had disorientation listed as not applicable. - The resident was semi-ambulatory with a wheelchair. <p>Review of Resident #8's Resident Register dated 5/24/13 revealed the resident had a habit of smoking.</p> <p>Review of resident record notes for Resident #8 revealed:</p> <ul style="list-style-type: none"> - A physician note dated 1/14/14 revealed the physician was aware the resident was a smoker. 	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 18</p> <ul style="list-style-type: none"> - There were no other notes found in the resident record related to smoking in the facility. <p>Review of facility shift notes where staff were to document smoking incidents revealed:</p> <ul style="list-style-type: none"> - Shift notes for May 2015 included on 5/20/15 during the 3rd shift, Resident #2 and Resident #8 were in Resident #8's bedroom smoking. - No other information in relation to this incident was included such as counseling and consequences related to the smoking in the facility. <p>Interview on 6/04/15 at 10:15 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - About a month ago she found a small burn mark on the commode seat in the bathroom of Resident #8. - Today she found ashes on the commode tank and on the commode seat in Resident #8's bathroom. <p>Observations on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - In the bathroom of Resident #8, 2 ash smears were on the commode seat and 1 very small burn mark was on the seat - Resident #8 's furniture had burn marks all over the tops of the dresser. <p>Interview on 6/04/15 at 11:45 a.m. with Resident #8 revealed:</p> <ul style="list-style-type: none"> - Residents were not supposed to smoke in the bathrooms or bedrooms. - Residents were to smoke only outside in the designated smoking areas. - The resident had not smoked in the facility since a few months ago. - Staff kept her cigarettes and lighter. 	{D 270}		6-8-15
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{D 270}	<p>Continued From page 19</p> <ul style="list-style-type: none"> - The resident did not know about the burn marks on the furniture. <p>Interview on 6/05/15 at p.m. with the Manager revealed:</p> <ul style="list-style-type: none"> - She was not aware of this incident although she said read through the shift notes daily. - She did not keep documentation of resident monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>2. Review of the FL-2 for Resident #6 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 7/15/02. - Diagnoses included Schizophrenia, History of Cocaine and Alcohol Abuse. <p>Review of the Resident Register dated 7/15/02 revealed:</p> <ul style="list-style-type: none"> - The resident's memory was adequate. - The resident had a personal habit of smoking. <p>Review of Resident #6's Assessment and Care Plan dated 4/07/15 revealed:</p> <ul style="list-style-type: none"> - The resident was independent with activities of daily living. - There was no information related to the resident smoking. <p>Review of resident record notes for Resident #6 revealed there were no notes found in the resident record related to smoking in the room or bathroom, consequences nor monitoring of the resident's behavior of smoking in the facility.</p>	{D 270}		<p>5-8-15</p>
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{D 270}	<p>Continued From page 20</p> <p>Observations on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - In the bedroom of Resident #6 there were ashes on the floor on the long side of the bed and ashes and a cigarette butt on the floor at the foot of the bed. <p>Interview on 6/04/15 at 4:15 p.m. a personal care aide revealed:</p> <ul style="list-style-type: none"> - Resident #6 had been known to smoke in the building. - Residents were not allowed to smoke in the facility. - Staff were to check on residents throughout their shift about every 1-2 hours. - Staff were to report observations of smoking to the Medication Aide (MA). - Resident #6 liked to light up in the building prior to going out the door. - The PCA would tell him to put it out and then go out and light up. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>3. Review of facility shift notes for Resident #2 where staff were to document smoking incidents revealed:</p> <ul style="list-style-type: none"> - Shift notes for May 2015 included on 5/20/15 during the 3rd shift, Resident #2 and Resident #8 were in Resident # 8's bedroom smoking. - No other information in relation to this incident was included. <p>Review of resident record notes for Resident #2</p>	{D 270}		6-8-15
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{D 270}	<p>Continued From page 21</p> <p>revealed there were no other notes found in the resident record related to smoking in the facility or consequences nor monitoring of the resident's behavior of smoking in the facility.</p> <p>Interview on 6/03/15 at 11:45 a.m. with Resident #2 revealed:</p> <ul style="list-style-type: none"> - The resident said smokers were only to use the smoking areas. - No one smoked inside. - She had not smoked in the building in May 2015 nor this month because of fires. - Staff have taken cigarettes and lighters if residents were caught smoking. - She had her smoking materials taken by staff before. <p>Interview on 6/05/15 at 2:10 p.m. with the Facility Manager revealed:</p> <ul style="list-style-type: none"> - She was not aware of this incident. - She would either be told by staff members about incidents of smoking as they happened or she would find out through reading the shift notes daily. - She did not keep documentation of resident behaviors, monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>4. Review of the current FL-2 for Resident #7 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 7/06/94. - Diagnoses included History of Dementia, and Alcohol Abuse. 	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 22</p> <ul style="list-style-type: none"> - Under the area of disorientation was "N/A" (non-applicable). <p>Review of the Resident Register for Resident #7 revealed:</p> <ul style="list-style-type: none"> - The resident's memory was adequate. - The resident had a personal habit of smoking. <p>Review of Resident #7's Assessment and Care Plan dated 1/26/15 included:</p> <ul style="list-style-type: none"> - Memory was adequate. - The resident was oriented. - The resident required limited assistance with eating, toileting, bathing, dressing and grooming. - Supervision was need for ambulation and transferring. - There was no documentation related to resident smoking. <p>Review of a physician note dated 4/09/15 revealed the resident had dementia.</p> <p>Review of a form in the resident's record dated and signed on 10/01/03 by Resident #7 included the following:</p> <ul style="list-style-type: none"> - Policies/Procedures at Admissions-Policies for Use of Smoking. - This form included a Fire Plan. - The Fire Plan documentation included: Prevent fires; watch for fires; do not allow trash or rubbish accumulate; observe and enforce smoking regulations; "Smoking in bed is prohibited." <p>Review of resident record notes for Resident #7 revealed there were no other notes found in the resident record related to smoking in the room or bathroom, consequences nor monitoring of the resident's behavior of smoking in the facility.</p> <p>Interveiw on 6/05/15 at 4:30 p.m. with a personal</p>	{D 270}		<p>6-8-15</p>
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{D 270}	<p>Continued From page 23</p> <p>care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - Resident #7 was caught smoking in his room on the evening shift about 1 -2 months ago. - The PCA said she would give a verbal warning the first time on the the shift the resident was caught. - The second time on the shift the resident was caught smoking the PCA would tell the Medication Aide (MA) or the Facility Manager. - Staff were to tell the resident to stop and then inform the (MA) or the Manager. - Residents were to be checked every 30 minutes or more often. - The MA usually wrote the incident in the notes. - The MA kept some residents smoking material and passed them out during the day including lighters. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>5. Review of the current FL-2 for Resident #9 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 4/26/07. - Diagnoses were listed as Tobacco Use, Chronic Obstructive Pulmonary Disease, and Chronic Paranoid Schizophrenia. <p>Review of the Resident Record dated 4/26/15 revealed the resident had a personal habit of smoking.</p> <p>Review of the Resident #9's Assessment and Care Plan dated 12/11/14 revealed:</p> <ul style="list-style-type: none"> - The resident was independent but needed some assistance with eating. - There was no documentation related to resident 	{D 270}		
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{D 270}	<p>Continued From page 24</p> <p>smoking.</p> <p>A physician note dated 12/12/14 revealed the resident should cut down on smoking.</p> <p>There were no facility notes or other documentation of smoking nor advising of facility house rules about no smoking in the facility in the resident's record related to smoking since 2/14/13.</p> <p>Interview on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - She found a cigarette butt in the commode of the bathroom of Resident #9 this morning. - She thought the resident got up in the morning and smoked in the bathroom. - She has found evidence of smoking in Resident #9's room often. - She told the Medication Aide (MA) or the facility Manager when it occurred. - The Manager would handle the resident after that. <p>Interview on 6/04/15 at 11:38 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - Resident #9's bedroom and bath had not been cleaned yet because he was asleep directly across from the bathroom in his room. - The cigarette butt in the commode she saw earlier was gone. - She thought the resident got up to the bathroom and probably flushed the butt left in the toilet before she could show the surveyor. <p>Interview on 6/04/15 at 4:00 p.m. with Resident #9 revealed:</p> <ul style="list-style-type: none"> - He knew residents were not to smoke in their rooms, but some did. - He only smoked outside. 	{D 270}		
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{D 270}	<p>Continued From page 25</p> <ul style="list-style-type: none"> - At night after the doors were locked at 9 p.m., the semi-enclosed smoking area was available for use. - The resident had smoked 3 or 4 nights ago in his room when he could not sleep. - The resident did not give a reason why he smoked in his room that night. - He knew smoking in his room could cause a fire and did not want a fire in the building. - He was aware, if caught smoking, staff would take his lighter and cigarettes away. - He had them taken away years ago and then he got them back and had not had them taken away for 2 years. - Facility staff took his cigarettes away once a couple of months ago again. - Staff check on residents once in a while on all the shifts but not more than every 1-2 hours. - He did not think he had signed a contract about not smoking in the building. - There was not a smoking policy other than they were not to smoke. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <hr/> <p>Interview on 6/05/15 2:10 p.m. with the Facility Manager revealed:</p> <ul style="list-style-type: none"> - The Facility manager had not been told about any residents still smoking in the facility. - They had tried to stop the smoking in the facility. - "As usual you can not do but so much." - She did not know what else to do to stop the smoking. 	{D 270}		
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{D 270}	<p>Continued From page 26</p> <ul style="list-style-type: none"> - She thought the only thing left was to make their facility a non smoking. - Staff were supposed to supervise residents for smoking by monitoring every 15 minutes. - She did not know staff were not monitoring for smoking every 15 minutes. - There was no place for staff to document the every 15 minute checks. - All rooms were to be checked on all shifts. - There were not any residents on oxygen in the facility now. - Staff were to escort any resident caught smoking in the facility out to the smoking area to smoke and tell them not to smoke in the facility. - Staff were to document in the shift notes or in the resident records when a resident caught smoking. - Staff were to report it to the MA and then the Facility Manger and/or the Resident Care Coordinator would be notified. - The Resident Care Coordinator would then review the smoking policy with the resident caught to ensure they understand. - They do not take away smoking materials but the facility had the right to confiscate smoking materials. - She then said the MA would give residents 4 -5 cigarettes and light the cigarette as needed on each shift. - The facility did not have a policy for discharge if residents continued to smoke in the building. - There had been a history of other consequences but they did not work out. - She did not know staff were not documenting the smoking incidents. - She did not keep documentation of resident behaviors, monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors given. 	{D 270}		
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{D 270}	<p>Continued From page 27</p> <p>Review of facility shift notes where staff were to document smoking incidents revealed:</p> <ul style="list-style-type: none"> - There were no shift notes provided for April 2015 after requested. - Shift notes for June 2015 did not reveal any documentation of smoking in the building. <p>Review of the facility's House Rules for Use of Smoking revealed:</p> <ul style="list-style-type: none"> - 1. Residents who smoke must use the designated smoking areas outside of the building. - 2. No smoking is allowed in resident rooms. - 3. Staff will supervise residents who smoke. - The home reserves the rights to confiscate all smoking materials if the resident fails to abide by smoking policies so as to insure fires safety for themselves and other residents. <hr/> <p>Review of the facility's Plan of Protection dated 6/05/15 included:</p> <ul style="list-style-type: none"> - The facility would immediately implement a facility security check list of rooms every 15 minutes with documentation of every resident known to be on the smoking list. - If caught smoking in room, smoking materials will be confiscated. - The facility manager will be notified of infractions of the rule and would come to the facility over the weekend to talk with residents caught smoking. - Staff will give cigarettes or smoking materials in the smoking area. - Staff will stay with smokers until they finish smoking. - The Medication Aide will communicate with Resident Care Coordinator and Facility Manager if someone is caught smoking in the facility. - The Facility manager will check the security 	{D 270}		
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{D 270}	Continued From page 28 check logs daily. - Meeting will be set up for all smokers to stress the warning and consequences of smoking in the facility. - The smoking policy will be revised. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20, 2015.	{D 270}		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation was abated. Non-compliance continues. Based on observation, interview and record review, the facility failed to contact the primary care physician for 1 of 5 sampled Residents (#4) with blood sugars greater or equal to 350 with 23 of 58 opportunities. The findings are: Review of Resident #4's current FL-2 dated 5/13/15 revealed: -The resident's diagnoses included Type 2 Diabetes Mellitus, diabetic neuropathy and chronic renal insufficiency.	{D 273}		

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{D 273}	<p>Continued From page 29</p> <p>-The resident had an order to check blood sugars twice daily.</p> <p>Review of the Resident Register revealed Resident #4 was admitted to the facility on 7/2/98.</p> <p>Resident #4's FL-2 dated 5/13/15 included the following medication orders: -Glipizide 5 milligrams (mg) give twice daily before meals (used to help control blood sugars). -An order for Lantus insulin 100 units (u) give 53 u subcutaneous (sq) at bedtime (long acting insulin used to help control blood sugars). -An order for Novolin R (Regular) Insulin use for sliding scale insulin (short acting insulin) used to help control blood sugars). If blood sugars are between 200 to 239 give 2 u; between 240 to 279 give 4 u; between 280 to 299 give 6 u; between 300 to 349 give 8 u; call the primary care physician if the blood sugars are 350 and give 8 u; if greater than 450 go to the emergency room (ER).</p> <p>Review of Resident #4's April 2015 Medication Administration Record (MAR) revealed: -There was documentation of the above sliding scale with the time, site and units given. -"Lantus 100 u inject 53 u at bedtime sq, increase Lantus 1-2 u at night each day until the morning glucose is stable 100-130" was transcribed on the MAR.</p> <p>Review of Resident #4's 8:00 a.m. (before breakfast) April 2015 blood sugar log revealed: -From 4/8/15-4/30/15, the resident's blood sugars ranged from 191-381. -On 4/10/15 and 4/12/15, the resident refused to have the blood sugars taken. -On 4/15/15, the resident's blood sugar was 355. There was no documentation the resident's</p>	{D 273}		
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{D 273}	<p>Continued From page 30</p> <p>primary care physician was notified. -On 4/20/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's 4:00 p.m. (before supper) April 2015 blood sugar log revealed: -From 4/8/15-4/30/15, the resident's blood sugars ranged from 214-464. -On 4/16/15, the resident refused to have blood sugars taken. -There was no documentation of the blood sugars taken on 4/28/15. -On 4/12/15, the resident's blood sugar was 424. There was no documentation the resident's primary care physician was notified. -On 4/13/15, the resident's blood sugar was 449. There was no documentation the resident's primary care physician was notified. -On 4/14/15, the resident's blood sugar was 472. There was no documentation the resident's primary care physician was notified. -On 4/16/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. -On 4/20/15, the resident's blood sugar was 421. There was no documentation the resident's primary care physician was notified. -On 4/21/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. -On 4/23/15, the resident's blood sugar was 395. There was no documentation the resident's primary care physician was notified. -On 4/25/15, the resident's blood sugar was 360. There was no documentation the resident's primary care physician was notified. -On 4/29/15, the resident's blood sugar was 364. There was no documentation the resident's primary care physician was notified.</p>	{D 273}		
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{D 273}	<p>Continued From page 31</p> <p>Review of Resident #4's May 2015 MAR revealed: -There was documentation of the blood sugars from 5/10/15-5/30/15. -There was documentation of the sliding scale with the time, site and units given. -"Lantus 100 u inject 53 u at bedtime sq, increase Lantus 1 u at night each day until the morning glucose is stable 100-130" was transcribed on the MAR.</p> <p>Review of Resident #4's May 2015 blood sugar log revealed: -From 5/1/15-5/19/15, the 8:00 a.m. blood sugars ranged from 153-355. The resident refused to have the blood sugar taken on 5/5/15. -From 5/1/15-5/19/15, the 4:00 p.m. blood sugars ranged from 260-460. The resident refused to have the blood sugar taken on 5/16/15.</p> <p>Review of a facility fax sheet attached to the May 2015 blood sugar log revealed the blood sugars from 5/1/15-5/19/15 was faxed to the primary care physician on 5/20/15.</p> <p>Review of Resident #4's primary care physicians' orders revealed: -An order dated 8/28/14 revealed to give the resident 28 u of Lanutus insulin sq at bedtime. -A subsequent order dated 10/9/14 revealed to give the resident 32 u of Lantus insulin at bedtime. May increase Lantus insulin 1 u nightly until am blood sugar is "around 120-130." -A subsequent order dated 5/12/15 revealed to increase Lantus insulin 1 units at night daily until the am glucose is stable around 120-130. -A current order dated 5/20/15 to increase Lantus insulin to 58 u. Increase Lantus insulin 1 u daily until am glucose "is around 120-130. Please</p>	{D 273}		
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{D 273}	<p>Continued From page 32</p> <p>continue on Regular insulin for sliding scale."</p> <p>Review of Resident #4's progress notes dated 5/19/15 revealed:</p> <ul style="list-style-type: none"> -The resident's primary care physician was contacted. -The resident's blood sugars ranged between 300-400. -The resident is up to 55 u of Lantus plus coverage. -The resident refused to go to the emergency room on 5/19/15. <p>Review of Resident #4's 8:00 a.m. May 2015 blood sugar log from 5/20/15-5/31/15 revealed:</p> <ul style="list-style-type: none"> -The blood sugars ranged from 111-429. -On 5/20/15, the resident was out of the facility. -On 5/31/15, the resident refused to have the blood sugars taken. -On 5/21/15, the resident's blood sugar was 365. There was no documentation the resident's primary care physician was notified. -On 5/26/15, the resident's blood sugar was 408. -On 5/29/15, the resident's blood sugar was 429. There was no documentation the resident's primary care physician was notified. <p>Review of Resident #4's 4:00 p.m. May 2015 blood sugar log from 5/20/15-5/31/15 revealed:</p> <ul style="list-style-type: none"> -The blood sugars ranged from 214-464. -On 5/20/15, the resident's blood sugar was 405. There was no documentation the resident's primary care physician was notified. -On 5/21/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. There was no documentation the resident's primary care physician was notified. -On 5/22/15, the resident's blood sugar was 372. There was no documentation the resident's 	{D 273}		
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{D 273}	<p>Continued From page 33</p> <p>primary care physician was notified.</p> <p>-On 5/23/15, the resident's blood sugar was 464. The blood sugar was rechecked at 8 p.m. and was 324. There was no documentation if the resident's primary care physician was notified or if the resident was sent to the ER.</p> <p>- On 5/27/15, the resident's blood sugar was 413. There was no documentation the resident's primary care physician was notified.</p> <p>-On 5/28/15, the resident's blood sugar was 454. There was no documentation the resident's primary care physician was notified or if the resident was sent to the ER.</p> <p>-On 5/30/15, the resident's blood sugar was 404. There was no documentation the resident's primary care physician was notified.</p> <p>-On 5/31/15, the resident's blood sugar was 354. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's progress note entry dated 5/26/15 at 5:00 p.m. documented by staff revealed:</p> <p>-The resident's primary care physician revealed to give the resident 59 u of Lantus insulin on 5/26/15 and increase 1 u of Lantus insulin nightly until the resident's glucose is between 120-130 in the am.</p> <p>-If the resident received up to 100 u of Lantus, it would be fine, because the physician was trying to find a dose of Lantus insulin, which would work for the resident.</p> <p>-Notify the physician if there are any changes in the blood sugars.</p> <p>-If the resident received up to 100 u of Lantus insulin it would be fine. The physician was trying to find a night dose of Lantus, which is why he requested the facility to increase the insulin 1 u each night until blood sugars ranged from 120-130.</p>	{D 273}		
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{D 273}	<p>Continued From page 34</p> <p>Review of Resident #4's June 2015 MAR revealed: -There was documentation of the sliding scale with the time, site and units given. -"Lantus 100 u inject 58 u at bedtime sq, increase Lantus 1 u at night each day until the morning glucose is stable 120-130" was transcribed on the MAR.</p> <p>Review of Resident #4's 8:00 a.m. June 2015 blood sugar log from 6/1/15-6/3/15 revealed: -The resident refused to have the blood sugars taken on 6/1/15. -On 6/2/15, the resident's blood sugar was 300. -On 6/3/15, the resident's blood sugar was 373. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's 4:00 p.m. June 2015 blood sugar log from 6/1/15-6/2/15 revealed: -On 6/1/15, the resident's blood sugar was 331. -On 6/2/15, the resident's blood sugar was 360. The resident's primary care physician was notified.</p> <p>Interview with a Medication Aide (MA) on 6/3/15 at 10:45 a.m. revealed: -Resident #4 had an order to contact the primary care physician if the sugar is 350 and to give 8 u of insulin. If the blood sugar is 450 and above to give 8 u of insulin and send to the ER. -The Lantus insulin is increased 1 u nightly if the a.m. blood sugars are not between a certain range. -Resident #4's blood sugars are 350 and above 3-4 days weekly. -Sometimes Resident #4 refused to go to the ER or physician's office. The physician just said to monitor the blood sugars. -The MA had not always contacted the Resident</p>	{D 273}		
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{D 273}	<p>Continued From page 35</p> <p>#4's primary care physician when the blood sugars were 350 and above or sent the resident to the ER when the blood sugars were 450 and above.</p> <ul style="list-style-type: none"> -On 5/27/15, Resident #4's a.m. blood sugar was 368. He gave the resident 8 u of insulin. -He rechecked the resident's blood sugar 15 minutes later and contacted the physician. -He could not provide documentation of contacting the physician. <p>Interview with another MA on 6/5/15 at 3:15 p.m. revealed:</p> <ul style="list-style-type: none"> -When Resident #4's blood sugars were 350 and above or 450 and above, he did not contact the resident's physician. -He should have contacted Resident #4's physician when the blood sugars were out of range. -There was no excuse to why he did not contact Resident #4's physician. <p>Interview with the Resident Care Coordinator (RCC) on 6/5/15 at 2:47 p.m. revealed:</p> <ul style="list-style-type: none"> -The RCC supervised the MAs -The MA should fax the physician when needed. -Weekdays, the MA will inform the RCC when they have faxed the resident's physician. -Resident #4's primary care physician responded better via fax. -She did not check blood sugar logs to make sure the MA's contacted the physician when the blood sugars were in a certain range. -She only checked the fax to make sure it was received by the resident's primary care physician. <p>Interview with the facility Manager on 6/5/15 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> -The MA and RCC should contact Resident #4's primary care physician when the blood sugars are 	{D 273}		
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395
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{D 273}	Continued From page 36 out of range. -If the RCC or MA cannot fax the resident's physician, inform the Manager and she would try to fax the resident's physician. -The RCC should check the blood sugar logs three times weekly to make sure MA's are contacting the resident's primary care physicians when needed. -She was not aware the RCC had not been checking the blood sugar logs to make sure staff are contacting the resident's physician as ordered. -She was notified on 6/5/15 Resident #4's primary care physician would no longer be working at the company. Resident #4 had to come to the care provider's office to be re-evaluated by another physician. Resident #4's primary care physician could not be reached by the end of the survey. The Administrator was not available for interview.	{D 273}		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by:	D 287		

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D 287	<p>Continued From page 37</p> <p>Based on observation, interview and record review, the facility failed to assure residents received a place setting (knife, fork, spoon) at every meal.</p> <p>The findings are:</p> <p>Interview with three residents on 6/2/15 between 10:56 a.m. and 11:39 p.m. revealed: -Residents received either a spoon or fork during the meals. -Residents did not receive a spoon, fork and knife with each meal. -The residents did not have a problem with only receiving a spoon or a fork. -The residents could not remember the last time they received a knife with the meals.</p> <p>Interview with a fourth resident on 6/2/15 at 11:45 a.m. revealed: -The resident received either a spoon or fork during the meals. -The resident did not receive a knife with each meal. -"It's tough trying to cut a piece of meat with a spoon." -The resident had not complained to anyone. -The resident could not remember the last time they received a spoon, knife and fork with the meals.</p> <p>Observation of the lunch meal in the dining room on 6/2/15 at 12:11 p.m. revealed the all of the residents received place setting, which included a spoon, fork and knife with the meal.</p> <p>Interview with a fifth resident on 6/2/15 at 3:11 p.m. revealed: -"We get a knife, fork and spoon most days." -"We usually get one or the other."</p>	D 287		

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D 287	<p>Continued From page 38</p> <p>-If the resident requested a knife, staff would give the resident a knife.</p> <p>-For breakfast on 6/2/15, the residents received a fork for breakfast. The resident did not have a problem with only receiving a fork for breakfast.</p> <p>-The resident could not remember the last time they received a spoon, knife and fork with the meals.</p> <p>Interview with a sixth resident on 6/5/15 at 2:31 p.m. revealed:</p> <p>-The residents usually received a fork with the meals.</p> <p>-The resident had to cut the meat with a fork.</p> <p>-"Sometimes they don't have a knife."</p> <p>-The resident could not remember the last time they received a spoon, knife and fork with the meals.</p> <p>Interview with two other residents between 6/2/15-6/5/15 (time unknown) revealed:</p> <p>-The residents had received a spoon, knife and fork for the first time in a long time.</p> <p>-The residents could not remember the last time they received a spoon, knife and fork.</p> <p>Observation of the dinner meal on 6/2/15 at 5:02 p.m. revealed all of the residents (20) in the dining room received a place setting, which included a spoon, fork and knife during the meal.</p> <p>Observation of the breakfast meal on 6/3/15 at 8:06 a.m. revealed all of the residents (36) in the dining room received place setting, which included a spoon, fork and knife during the meal.</p> <p>Interview with two staff, who served meals to the resident, on 6/3/15 at 11:51 a.m. revealed:</p> <p>-The residents always received a knife, fork and spoon with the meals.</p>	D 287		
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D 287	<p>Continued From page 39</p> <p>-No residents had ever complained on not receiving a knife, fork and spoon with meals.</p> <p>Interview with the Cook on 6/3/15 at 11:55 a.m. revealed:</p> <p>-Every meal the residents received a spoon, fork and knife.</p> <p>-The Cook was responsible for setting the table, which included placing the spoon, fork and knife on the table.</p> <p>-No residents had ever complained on not receiving a spoon, fork and knife at every meal.</p> <p>-The residents had received the place settings at least since January 2015.</p> <p>Interview with the Dietary Supervisor on 6/3/15 at 12:01 p.m. revealed:</p> <p>-At every meal, dietary set the table which included putting a place setting on the table for the residents.</p> <p>-The place setting included a spoon, fork and knife for the residents.</p> <p>-For the past six years, the residents had received a place setting at every meal.</p> <p>-No residents had complained of not receiving a spoon, fork and knife at every meals.</p> <p>Observation of the lunch meal on 6/3/15 at 12:03 p.m. revealed all of the residents (33) in the dining room received a place setting, which included a spoon, fork and knife during the meal.</p> <p>Interview with the Resident Care Coordinator on 6/5/15 at 2:47 p.m. revealed:</p> <p>-The facility Manager was responsible for dietary.</p> <p>-She does not check the dining room to make sure residents received a spoon, fork and knife during meals.</p> <p>Interview with the facility Manager on 6/5/15 at</p>	D 287		
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D 287	<p>Continued From page 40</p> <p>4:00 p.m. revealed: -She was responsible for dietary. -The residents may have only a spoon and fork with the meals. Some of the residents may not receive a knife with a meal, because of the resident's mental health diagnoses. She could not provide names of resident who should not receive a knife. -Sometimes the residents may only receive a spoon, because the meal only require the use of a spoon. -She was unsure if the residents received a knife with the meals. -She was aware the residents should receive a spoon, fork and knife at every meal.</p> <p>The Administrator was not available for interview.</p> <p>{D 338} 10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, were maintained and exercised without hindrance.</p> <p>The findings are:</p> <p>Cross refer to Tag D911, G.S. 131D-21(1) Declaration of Residents' Rights.</p>	D 287		

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{D 338}	Continued From page 41 Based on observation and interview, the facility failed to assure 2 of 2 residents were treated with respect, consideration, dignity and full recognition of individuality and right to privacy by not providing curtains, draperies or blinds in a shared room.	{D 338}		
{D911}	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION</p> <p>The Type B Violation was abated. Non-compliance continues.</p> <p>Based on observation and interview, the facility failed to assure 2 of 2 residents were treated with respect, consideration, dignity and full recognition of individuality and right to privacy by not providing curtains, draperies or blinds in a shared room.</p> <p>The findings are:</p> <p>Observation of room #205 on 6/5/15 1:15pm revealed no curtains or blinds covering the large window of the room.</p> <p>One confidential resident interview revealed: -There had not been blinds in room #205 as long as this staff could remember.</p>	{D911}	<p>MAINTENANCE will put up another Blind to the window and the manager will →</p>	<p>8-26-15</p>

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{D911}	<p>Continued From page 42</p> <p>One confidential staff interview revealed:</p> <ul style="list-style-type: none"> -There had been blinds a month ago in room #205. -Every time someone put up new blinds the resident would grab the blinds by the cord or jerk the blinds anyway possible. -Staff were afraid the blinds being pulled down like that would possibly hurt the 2 residents in the room. -Staff had mentioned this to management. -Staff was told there was no use putting up blinds because the resident would pull them down. -The resident that pulled the blinds down required changing of incontinent pads. <p>Interview with the facility manager on 6/5/15 at 6:15pm revealed:</p> <ul style="list-style-type: none"> -There had been 6 sets of blinds put up in room #205. -The resident will snatch the blinds down anyway he can. -She had mentioned to the maintenance man about some way to secure the pull cords of the blinds. -The maintenance man was very busy. -She did not believe the owner was aware of the missing blinds. <p>The maintenance man could not be reached by the end of the survey.</p> <p>The Administrator was not available for interview.</p>	{D911}	<p>Check All rooms twice a week along with the house keepers to make sure residents have what they need:</p>	6-26-15
{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:</p> <p>2. To receive care and services which are</p>	{D912}		

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{D912}	<p>Continued From page 43</p> <p>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 review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to residents smoking inside the facility.</p> <p>The findings are:</p> <p>Based on observation, interview and record review, the facility failed to assure 5 of 5 sampled residents did not smoke in the facility. (# 2, #6, # 7, # 8, # 9). [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type B Violation)]</p>	{D912}		
{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</p>	{D992}	<p>manager will make sure each new employee has a Drug Screening Completed prior to Hire Date. And All Staff that was hired effectively 9-30-13 will be tested immediately.</p>	<p>9-1-15</p>

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{D992}	<p>Continued From page 44</p> <p>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: Based on interviews and record reviews, the facility failed to require an examination and screening for the presence of controlled substances required for applicants for employment in adult care homes for 3 of 3 sampled staff. (B, E, G).</p> <p>The findings are:</p> <p>A. Review of Staff B's personnel record revealed: -The hire date was 4/15/15. -No documentation of a drug screen.</p> <p>Interview with Staff B on 6/5/15 at 12:55pm revealed: -No drug screen was required upon hire. -She could not recall if she had been told a drug screen would be required in the future.</p>	{D992}		<p>9-1-15</p>
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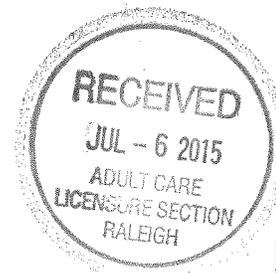
{D992}	<p>Continued From page 45</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>B. Review of Staff E's personnel record revealed: -The hire date was 11/1/13. -No documentation of a drug screen.</p> <p>Staff E was not available for interview.</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>C. Review of Staff G's personnel record revealed: -The hire date was 5/11/15. -No documentation of a drug screen.</p> <p>Staff G was not available for interview.</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>Interview with the facility Manager on 6/5/15 at 12:55am revealed: -The facility did not require drug screens upon hire. -The owner had communicated he was going to contract a company to provide that service but nothing had been done about it. -She was aware of the rule requirement. -The owner was aware of the rule requirement from the last survey.</p> <p>The Administrator was not available for interview.</p>	{D992}		<p>9-1-15</p>
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on June 2-5, 2015.	{D 000}		
{D 072}	<p>10A NCAC 13F .0305(m) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.</p> <p>This Rule is not met as evidenced by: Based on observation and interview the facility failed to assure the outside grounds of the facility were maintained in a clean and safe condition.</p> <p>The findings are:</p> <p>Observation on 6/5/15 at 4:20pm revealed:</p> <ul style="list-style-type: none"> - The back side of the building had faded white and black paint on the walls. - The front left side of the building had a ladder and a large paint can on the ground. - The storage shed was covered in peeling paint. - Two very large facility signs were leaned against the right side of the shed. - Two of the four sign posts, on this sign had concrete chunks attached where they had been imbedded in the ground. - A large stack of white plastic water pipes and black drainage pipes were piled up next to the 	{D 072}	 <p>7-14-15</p> <p>↓ maintenance is responsible for moving all unused items from and around the Facility. manager has spoken with maintenance again</p>	

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

Lisa Boesku

TITLE
manager

(X6) DATE
6-30-15

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{D 072}	<p>Continued From page 1</p> <p>shed on the left side.</p> <p>Observation on 6/5/15 at 4:20pm revealed there were still multiple items sitting outside the storage building in the back yard of the building such as a rusty bedframe, 6 mattresses, a recliner with ripped upholstery, Geri-chair, bedside commode, bedside dresser, and multiple stacks of bricks.</p> <p>Observation on 6/2/15 at 4:25pm revealed:</p> <ul style="list-style-type: none"> -There was a brick area on the outside smoking courtyard next to the activity room. -The ground was exposed where an area 5 by 5 feet of missing bricks presented a trip hazard. -Multiple smokers walked in and out of the smoking area. -The ground underneath some of the bricks was uneven. <p>Observation on 6/5/15 at 6:10pm revealed:</p> <ul style="list-style-type: none"> -The brick patio smoking area still contained missing bricks and an uneven terrain. <p>Two confidential staff interviews revealed:</p> <ul style="list-style-type: none"> -Staff did not believe the items around the facility's storage shed presented a safety concern for the residents. -There used to be more items around the shed and the facility's maintenance man had removed them. <p>Interview with a resident on 6/2/15 at 10:56 am revealed the resident had no problems with the outside premise.</p> <p>Interview with a second resident on 6/2/15 at 11:19am revealed the resident had no problems with the outside cleanliness of the facility.</p> <p>Interview with a third resident on 6/2/15 at 11:45am revealed:</p>	{D 072}	<p>so the unwanted items can be removed once it's removed, manager with maintior outside grounds along with the house keepers to ensure grounds are kept clean.</p>	<p>7-14-15</p>
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{D 072}	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The outside of the building was clean. -The yard had been mowed 3-4 days ago. <p>Interview with a fourth resident on 6/2/15 at 3pm revealed the resident was unsure how often the outside of the building was cleaned.</p> <p>Interview with the facility Manager on 6/5/15 at 6:15pm revealed:</p> <ul style="list-style-type: none"> -She was aware there were still items around the facility's storage shed. -There were only certain days the dump was open to discard items around the storage shed. -The owner had told staff he had plans to get rid of the items around the facility's storage shed but had not told staff in what time frame. -No residents had tripped or gotten hurt because of the missing bricks. -She had talked with the maintenance man about removing the bricks and starting all over to redesign this area as a patio. -She did not know when the remodeling was going to start. -The maintenance man was very busy as he has to cover 2 facilities. -The maintenance man was not available for an interview. <p>The Maintenance man could not be reached by the end of the survey.</p> <p>The Administrator was not available for interview.</p>	{D 072}		7-14-15
{D 074}	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall:</p>	{D 074}		

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{D 074}	Continued From page 3 (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Non-compliance continues	{D 074}		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 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. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the facility did not use hazardous insecticide sprays inside of the facility. The findings are: Observations of resident room 106 on 6/03/15 at 11:45 a.m. revealed: - Multiple flies in a resident's room. - Several flies were crawling around on the bed. - Four flies were moving around on the top of the dresser. - Two flies were on the side table near the window. - Three flies were on the window sill. Interview on 6/03/15 at 11:45 a.m. with two residents in the room revealed:	D 079	owner is consulting with the exterminator to find the most safest fly spray that we can use in our metered spray units. those sprayer will be, →	1-23-15

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D 079	<p>Continued From page 4</p> <ul style="list-style-type: none"> - There were flies off and on in rooms lately. - They were bothersome at times but were not so bad today. <p>Observation on 6/04/15 at 11:30 p.m. of three resident rooms on the 100 Hall revealed each room had two - five flies on the furniture and two - three flies on the beds.</p> <p>Interview on 6/04/15 at 11:35 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - There were many flies in the facility at different times of the year. - They were better yesterday with the rain but are worse today. - She said they would be even worse if she did not keep the sprayers full with the cans throughout the facility. - The flies kept her busy changing the cans in the timed sprayers on the walls throughout the facility. - The cans went into the sprayer units to kill flies, spiders and other bugs. - She kept a full can on her cart to use when a sprayer was out of insecticide. <p>Observation on 6/04/15 at 11:45 a.m. of the 100 Hall revealed:</p> <ul style="list-style-type: none"> - There were 4 metered insecticide spray units attached to the walls at the ceiling level and one at the exit door. - The metered spray units had brown and tan drip marks on the outside covers. <p>Observations on 6/04/15 of the 100 Hall revealed the following:</p> <ul style="list-style-type: none"> - At 11:47 a.m., a resident was swatting at a fly around his face and head with his hands as he stood near the nurse station. - At 12:05 p.m., a resident was walking on the 	D 079	<p>Monitor by the House-keeping Supervisor once a week to ensure Flies are kept out of the Facility and residents rooms. Also several spray units have been removed due to irritation of residents.</p>	7-23-15
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D 079	<p>Continued From page 5</p> <p>100 Hall directly underneath one of the 4 insecticide spray units in the hallway.</p> <ul style="list-style-type: none"> - At 12:06 p.m. a resident was standing near the insecticide spray unit at the nurses station area. - At 12:10 p.m. an insecticide metered spray unit was observed across from a resident room 119 on the 100 Hall. - At 12:20 p.m. an insecticide metered spray unit was observed on the wall of the activity room at the doorway to the outside smoking area. <p>Interview with a resident in the hall on 6/04/15 at 12:07 p.m. revealed she thought the insecticide spray unit was an air freshener spray and did not know it was was to kill insects.</p> <p>Interview on 6/04/15 at 12:10 p.m. with another resident revealed.</p> <ul style="list-style-type: none"> - The resident did not like the spray units for flies and other insects. - "I do not want it on me!" - It sprays every 15 - 25 minutes day and night. <p>Subsequent interview on 6/05/15 at 2:45 p.m. with the same resident revealed:</p> <ul style="list-style-type: none"> - About 2 months ago the resident asked the housekeeper to remove the can of insecticide in the spray unit on the wall directly across from his room. - When the unit sprayed the fog of the insecticide, it went half way across the hall. - His concern was that if it killed insects, what was it doing to him? - The spray made his skin feel itchy and dry. - He would wash it off briefly. - He had been feeling much better without the spray directly in front of his room. - He could leave the door open now even though it was still spraying in other areas of the hall. - He did not tell anyone but the housekeeper. 	D 079		7-23-15

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D 079	<p>Continued From page 6</p> <p>Observations on 6/04/15 revealed the following:</p> <ul style="list-style-type: none"> - At 12:15 p.m. a metered insecticide spray unit was attached to the wall at the dining room entrance. - At 12:16 p.m. a metered spray unit was attached to the wall near the managers' office and the front entrance area television room. - At 12:28 p.m. a metered spray unit was attached to the wall at the entrance door of the facility. <p>Interview with a resident walking near a metered spray unit by the television room on 6/04/15 at 12:16 p.m. revealed:</p> <ul style="list-style-type: none"> - He said the unit sprayed out about 10 inches to 1 foot into the hallway every so often. - The spray killed the flies. - It did not bother him but there were a lot of flies. <p>Observations on 6/04/15 at 12:18 p.m. of the 200 Hall revealed the following:</p> <ul style="list-style-type: none"> - Three insecticide metered spray units were attached to the walls of the 200 Hall. - An insecticide metered spray unit was observed on the wall near resident rooms 206 and 208 which had open doors. - An insecticide metered spray unit was toward the middle of the hallway on the wall. - An insecticide metered spray unit was attached to the wall near the ceiling at the exit door at the end of the 200 Hall. - Two resident rooms had multiple flies on furniture and beds. <p>Interviews on 6/04/15 at 2:55 p.m. with two residents revealed:</p> <ul style="list-style-type: none"> - One resident said flies are in the bedrooms a lot and they bother her. - They were in the dining room and the 	D 079		7-23-15

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D 079	<p>Continued From page 7</p> <p>bedrooms.</p> <ul style="list-style-type: none"> - The other resident agreed they were in the bedrooms. - One resident did not like it when flies went around her head. <p>Interview on 6/04/15 at 1:05 p.m. with the facility Manager revealed:</p> <ul style="list-style-type: none"> - The insecticide metered spray units were used all year round in the facility. - The units have a timer and they usually set it to spray every 30 minutes. - She was not aware of the hazards listed on the cans of insecticide used in the sprayers. - She would have hoped residents would have told her about not liking the sprayers so she could have looked into it. - The Administrator ordered the insecticide cans for the metered spray units. - She was not aware of any residents with skin, respiratory or eye reactions to the spray. - When asked, the facility Manager said she would remove the spray insecticide from the sprayers today. <p>Interview on 6/05/15 at 3:20 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - He had used the insecticide sprayers for 25 years and had never heard of a problem with them. - He was not aware of the hazards listed on the label of the insecticide cans. - He would look into the concern with the health department and the sanitation department. - He does not agree with this, but asked the facility Manager to remove the insecticide cans from the building. <p>Review of the can label on the insecticide used in the metered wall sprayers revealed:</p>	D 079		7-23-15
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D 079	<p>Continued From page 8</p> <ul style="list-style-type: none"> - The can label included the contents were to be used as a metered insecticide. - The unit with insecticide was a time released aerosol to be used only in commercial food service areas and preparation areas of milk houses, hospitals, hotels factories, ships and others. <p>Continued review of the label included:</p> <ul style="list-style-type: none"> - "Precautionary Statements" "Hazards to Humans and Domestic Animals." - Cautions included: harmful if swallowed or absorbed through the skin; do not breathe vapors or spray mist and do not get in the eyes or on skin. <p>Further review of the can label included first aide instructions</p> <ul style="list-style-type: none"> - Inhalation - move to fresh air; If not breathing cal 911; Give CPR(cardio-pulmonary resuscitation); call poison control. - Skin/clothing - Take off clothing rinse skin thoroughly with water for 15 -20 minutes; call poison control. - Eyes- Hold eye open and rinse with water slowly for 15-20 minutes. - Swallow- call poison control or medical doctor immediately. <p>Further review revealed, "Restrictions: Do not use in nurseries and rooms where infants were or where ill or aged persons were located.</p> <p>Review of the metered insecticide company's Safety Data Sheet for this product revealed:</p> <ul style="list-style-type: none"> - Under Toxicological Information section, "Medical Condition Aggravated: Excessive exposure will aggravate respiratory cardiovascular or pulmonary illnesses. - Under a section listed as Chronic Health 	D 079		7-23-15
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D 079	Continued From page 9 Hazards: Concentrating vapors and inhaling material can lead to oxygen deprivation, loss of brain function and potential loss of life."	D 079	↓	
{D 150}	<p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>(a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service-Center, Raleigh, NC 27699-2708.</p> <p>(b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review.</p> <p>This Rule is not met as evidenced by: Based on observations, interview and record review, the facility failed to assure that staff who provide or directly supervise staff that provide personal care to residents had successfully completed an 80 hour personal care training and competency evaluation established by the department within six months after hiring</p>	{D 150}	<p style="text-align: center;">↓</p> <p>Personal Care Training Classes have started as of 6-8-15. giving by, Patricia Martin, all staff are taking the class, two classes are required, Any new employees will also be required to take the class, manager will monitor.</p> <p style="text-align: center;">↓</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">7-23-15</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">6-8-15</p>

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{D 150}	<p>Continued From page 10</p> <p>for staff hired after September 1, 2003 for 4 of 6 sampled staff. (C, D, E, F).</p> <p>The findings are:</p> <p>A. Review of Staff C's personnel record revealed: -No documentation of personal care (PC) training hours. -The hire date was 8-11-10.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff C was not available for interview.</p> <p>B. Review of Staff D's personnel record revealed: -No documentation of PC training hours. -The hire date was 12/12/10.</p> <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff D was not available for interview.</p> <p>C. Review of Staff E's personnel record revealed: -No documentation of PC training hours. -The hire date was 11-1-13.</p> <p>Refer to memo in the medication room revealed.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Staff E was not available for interview.</p> <p>D. Review of Staff F's personnel record revealed:</p>	{D 150}		<p>6-8-15</p>
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{D 150}	<p>Continued From page 11</p> <ul style="list-style-type: none"> -No documentation of PC training hours. -The hire date was 7-22-13. <p>Interview with Staff F on 6/5/15 at 3:30pm revealed:</p> <ul style="list-style-type: none"> -There had been no requirement for PC training upon hire. -There had been no training on PC hours since hire but a training was scheduled within the week. -Staff F had provided personal care at other facilities and felt experienced. <p>Refer to memo in the medication room.</p> <p>Refer to interview with the facility's Manager on 6/4/15 at 9am.</p> <p>Review of memo in the medication room revealed:</p> <ul style="list-style-type: none"> -A mandatory classes for all 2nd and 3rd shift Personal Care Aides (PCA) was scheduled for 6-8-15 from 9am-1pm. -Staff C, D, E, and F were scheduled to take the class. <p>Interview with the facility's Manager on 6/4/15 at 9am revealed:</p> <ul style="list-style-type: none"> -Staff C, D, E, and F had no PCA training through her facility. -Staff C, D, E, and F had not been required to receive the training within 6 months after hire. -She was aware of the rule area requirement. -Three staff had their 80 hours of training as they were Nursing Assistants. -Nine PCA's were currently working at the facility without their personal care hours. -She did not know how to find a provider for the training. -She could not find the resources. -She had talked to various pharmacies and 	{D 150}		<p>6-8-15</p>
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{D 150}	Continued From page 12 inquired to the required training. -The facility's current pharmacy was contracted to provide the training within the week.	{D 150}	↓	
{D 270}	<p>10A NCAC 13F .0901(b).Personal Care and Supervision</p> <p>10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION</p> <p>The Type A2 Violation is abated.</p> <p>THIS IS A TYPE B VIOLATION.</p> <p>Based on observation, interview and record review, the facility failed to assure 5 of 5 sampled residents did not smoke in the facility. (#2, #6, #7, # 8, #9). The findings are:</p> <p>Tour of the facility on 6/04/15 at 8:30 a.m. revealed:</p> <ul style="list-style-type: none"> - A no smoking sign was at the entrance door. - No smoking signs were on every resident room door. - A smoking policy was not posted. <p>Interview on 6/3/15 at 10:30 a.m. with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - All residents were checked every 1-2 hours. - Residents who smoked were checked at the same times. 	{D 270}		<p>A. Addendum has been Implenmented, in the Smoking Policy for All Smokers in the Facility. ALSO STAFF has a Checklist AND will check each Resident</p>

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{D 270}	<p>Continued From page 13</p> <ul style="list-style-type: none"> - If residents were caught smoking, the PCA would tell the Medication Aide (MA). - The PCA had not seen anyone smoking in the facility nor smelled or seen smoke. - There had not been any fires in the facility. <p>Interview on 6/04/15 at 8:35 a.m. with two residents in the facility who were smoking in the outside front smoking area revealed:</p> <ul style="list-style-type: none"> - They both said residents were to smoke only in the outside smoking areas. - There are cans to put butts in. - No fires in the facility and residents participate in fire drills. - Both residents said staff keeps most residents' smoking materials including lighters. - A few residents are allowed to keep their own. <p>Interview on 6/04/15 at 10:15 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - She worked the day shift and cleaned resident rooms, their bathrooms, common baths and other areas. - Residents continued to smoke in bedrooms and bathrooms. - The smoking frequency was better now than a few months ago, but some residents continued to smoke in the building. - She had not seen smoke nor actually observed a resident smoking for 2 months when she had seen and smelled smoke in the hall the Medication Aide (MA) was notified. - Everyday she found and cleaned up cigarette ashes and butts in bathroom toilets, on the floors and on the beds for Residents #6, #8 and #9 and others. - She had not observed any burn holes on bed linen or on floors. - In the last couple of months the housekeeper had taken smoking evidence found and/or the 	{D 270}	<p>That smoke to ensure no one is smoking in the facility. manager, along with R.C.C. Also medication aides are maintaining the check list daily.</p> 	6-8-15
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/05/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395
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{D 270}	<p>Continued From page 14</p> <p>resident to the Facility Manager, Resident Care Director or the MA.</p> <ul style="list-style-type: none"> - Management staff would then talk with the resident and decide what to do next. <p>Interview on 6/04/15 at 4:15 p.m. with a PCA revealed:</p> <ul style="list-style-type: none"> - Residents had been known to smoke in the building. - Residents were not allowed to smoke in the facility. - Staff were to check on all residents throughout their shift about every 1-2 hours. - Staff were to report observations of smoking to the MA. - MA and the Facility Manager completed documentation of these incidents. <p>Interview on 6/05/14 at 2:30 p.m. with a MA revealed:</p> <ul style="list-style-type: none"> - Staff were to supervise residents by monitoring every 30 minutes for smoking in the facility and the same for the nonsmokers. - Staff were to document the incidences in the Shift Notes. - The MA said they keep wheelchair residents' smoking materials including lighters. - They give 3-4 cigarettes at a time for a shift. and they can get more later in the day and evening. - Residents who are independent can keep their own smoking materials. <p>Interview on 6/05/15 at 4:30 p.m. with a PCA revealed:</p> <ul style="list-style-type: none"> - If residents were caught smoking, staff were to tell the resident to stop and then inform the MA or the Facility Manager. - The MA usually wrote the incident in the notes. - The MA kept some residents smoking materials 	{D 270}	<p><i>ALSO A Policy for All Smokers will be posted on both HALLS by Facility manager.</i></p> 	<p><i>7-8-15</i></p>
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395		
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{D 270}	Continued From page 15 including lighters and then passed them out during the day and evening. - The PCA might give one warning and then tell the MA if they smoked in the facility again on the shift. Interview on 6/05/15 at 6:40 p.m. with the Facility Manager revealed lighters could be confiscated. Interview on 6/05/15 at 6:40 p.m. with a MA revealed residents who smoked usually received 5 cigarettes per shift. 1. Review of the FL-2 dated 7/21/14 for Resident #8 revealed: - The resident was admitted on 5/24/13. - Diagnoses included Schizoaffective Disorder, Diabetes Mellitus II and Amputation of the Right Foot. - The FL-2 had disorientation listed as not applicable. - The resident was semi-ambulatory with a wheelchair. Review of Resident #8's Resident Register dated 5/24/13 revealed the resident had a habit of smoking. Review of resident record notes for Resident #8 revealed: - A physician note dated 1/14/14 revealed the physician was aware the resident was a smoker. - There were no other notes found in the resident record related to smoking in the facility. Review of facility shift notes where staff were to document smoking incidents revealed: - Shift notes for May 2015 included on 5/20/15 during the 3rd shift, Resident #2 and Resident #8 were in Resident	{D 270}			6-8-15

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{D 270}	<p>Continued From page 16</p> <p>#8's bedroom smoking.</p> <ul style="list-style-type: none"> - No other information in relation to this incident was included such as counseling and consequences related to the smoking in the facility. <p>Interview on 6/04/15 at 10:15 a.m. with a housekeeper revealed:</p> <ul style="list-style-type: none"> - About a month ago she found a small burn mark on the commode seat in the bathroom of Resident #8. - Today she found ashes on the commode tank and on the commode seat in Resident #8's bathroom. <p>Observations on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - In the bathroom of Resident #8, 2 ash smears were on the commode seat and 1 very small burn mark was on the seat - Resident #8 's furniture had burn marks all over the tops of the dresser. <p>Interview on 6/04/15 at 11:45 a.m. with Resident #8 revealed:</p> <ul style="list-style-type: none"> - Residents were not supposed to smoke in the bathrooms or bedrooms. - Residents were to smoke only outside in the designated smoking areas. - The resident had not smoked in the facility since a few months ago. - Staff kept her cigarettes and lighter. - The resident did not know about the burn marks on the furniture. <p>Interview on 6/05/15 at p.m. with the Manager revealed:</p> <ul style="list-style-type: none"> - She was not aware of this incident although she said read through the shift notes daily. - She did not keep documentation of resident 	{D 270}		<p>6-8-15</p>

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{D 270}	<p>Continued From page 17</p> <p>monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors.</p> <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>2. Review of the FL-2 for Resident #6 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 7/15/02. - Diagnoses included Schizophrenia, History of Cocaine and Alcohol Abuse. <p>Review of the Resident Register dated 7/15/02 revealed:</p> <ul style="list-style-type: none"> - The resident's memory was adequate. - The resident had a personal habit of smoking. <p>Review of Resident #6's Assessment and Care Plan dated 4/07/15 revealed:</p> <ul style="list-style-type: none"> - The resident was independent with activities of daily living. - There was no information related to the resident smoking. <p>Review of resident record notes for Resident #6 revealed there were no notes found in the resident record related to smoking in the room or bathroom, consequences nor monitoring of the resident's behavior of smoking in the facility.</p> <p>Observations on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - In the bedroom of Resident #6 there were ashes on the floor on the long side of the bed and ashes and a cigarette butt on the floor at the foot of the bed. 	{D 270}		6-8-15

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{D 270}	<p>Continued From page 20</p> <p>Review of Resident #7's Assessment and Care Plan dated 1/26/15 included:</p> <ul style="list-style-type: none"> - Memory was adequate. - The resident was oriented. - The resident required limited assistance with eating, toileting, bathing, dressing and grooming. - Supervision was need for ambulation and transferring. - There was no documentation related to resident smoking. <p>Review of a physician note dated 4/09/15 revealed the resident had dementia.</p> <p>Review of a form in the resident's record dated and signed on 10/01/03 by Resident #7 included the following:</p> <ul style="list-style-type: none"> - Policies/Procedures at Admissions-Policies for Use of Smoking. - This form included a Fire Plan. - The Fire Plan documentation included: Prevent fires; watch for fires; do not allow trash or rubbish accumulate; observe and enforce smoking regulations; "Smoking in bed is prohibited." <p>Review of resident record notes for Resident #7 revealed there were no other notes found in the resident record related to smoking in the room or bathroom, consequences nor monitoring of the resident's behavior of smoking in the facility.</p> <p>Interveiw on 6/05/15 at 4:30 p.m. with a personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - Resident #7 was caught smoking in his room on the evening shift about 1 -2 months ago. - The PCA said she would give a verbal warning the first time on the the shift the resident was caught. - The second time on the shift the resident was caught smoking the PCA would tell the 	{D 270}		0-8-15

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{D 270}	<p>Continued From page 21</p> <p>Medication Aide (MA) or the Facility Manager.</p> <ul style="list-style-type: none"> - Staff were to tell the resident to stop and then inform the (MA) or the Manager. - Residents were to be checked every 30 minutes or more often. - The MA usually wrote the incident in the notes. - The MA kept some residents smoking material and passed them out during the day including lighters. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <p>5. Review of the current FL-2 for Resident #9 revealed:</p> <ul style="list-style-type: none"> - The resident was admitted on 4/26/07. - Diagnoses were listed as Tobacco Use, Chronic Obstructive Pulmonary Disease, and Chronic Paranoid Schizophrenia. <p>Review of the Resident Record dated 4/26/15 revealed the resident had a personal habit of smoking.</p> <p>Review of the Resident #9's Assessment and Care Plan dated 12/11/14 revealed:</p> <ul style="list-style-type: none"> - The resident was independent but needed some assistance with eating. - There was no documentation related to resident smoking. <p>A physician note dated 12/12/14 revealed the resident should cut down on smoking.</p> <p>There were no facility notes or other documentation of smoking nor advising of facility house rules about no smoking in the facility in the</p>	{D 270}		6-8-15

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{D 270}	<p>Continued From page 22</p> <p>resident's record related to smoking since 2/14/13.</p> <p>Interview on 6/04/15 at 10:25 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - She found a cigarette butt in the commode of the bathroom of Resident #9 this morning. - She thought the resident got up in the morning and smoked in the bathroom. - She has found evidence of smoking in Resident #9's room often. - She told the Medication Aide (MA) or the facility Manager when it occurred. - The Manager would handle the resident after that. <p>Interview on 6/04/15 at 11:38 a.m. with the housekeeper revealed:</p> <ul style="list-style-type: none"> - Resident #9's bedroom and bath had not been cleaned yet because he was asleep directly across from the bathroom in his room. - The cigarette butt in the commode she saw earlier was gone. - She thought the resident got up to the bathroom and probably flushed the butt left in the toilet before she could show the surveyor. <p>Interview on 6/04/15 at 4:00 p.m. with Resident #9 revealed:</p> <ul style="list-style-type: none"> - He knew residents were not to smoke in their rooms, but some did. - He only smoked outside. - At night after the doors were locked at 9 p.m., the semi-enclosed smoking area was available for use. - The resident had smoked 3 or 4 nights ago in his room when he could not sleep. - The resident did not give a reason why he smoked in his room that night. - He knew smoking in his room could cause a 	{D 270}		<p>6-8-15</p>
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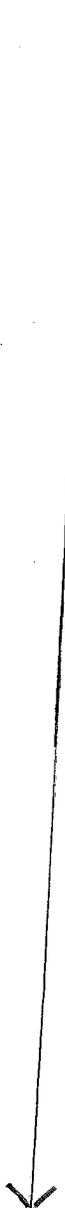
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{D 270}	<p>Continued From page 23</p> <p>fire and did not want a fire in the building.</p> <ul style="list-style-type: none"> - He was aware, if caught smoking, staff would take his lighter and cigarettes away. - He had them taken away years ago and then he got them back and had not had them taken away for 2 years. - Facility staff took his cigarettes away once a couple of months ago again. - Staff check on residents once in a while on all the shifts but not more than every 1-2 hours. - He did not think he had signed a contract about not smoking in the building. - There was not a smoking policy other than they were not to smoke. <p>Refer to Interview on 6/05/15 2:10 p.m. with the Facility Manager.</p> <p>Refer to the review of the facility's House Rules for Use of Smoking.</p> <hr/> <p>Interview on 6/05/15 2:10 p.m. with the Facility Manager revealed:</p> <ul style="list-style-type: none"> - The Facility manager had not been told about any residents still smoking in the facility. - They had tried to stop the smoking in the facility. - "As usual you can not do but so much." - She did not know what else to do to stop the smoking. - She thought the only thing left was to make their facility a non smoking. - Staff were supposed to supervise residents for smoking by monitoring every 15 minutes. - She did not know staff were not monitoring for smoking every 15 minutes. - There was no place for staff to document the every 15 minute checks. 	{D 270}		6-8-15

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{D 270}	<p>Continued From page 24</p> <ul style="list-style-type: none"> - All rooms were to be checked on all shifts. - There were not any residents on oxygen in the facility now. - Staff were to escort any resident caught smoking in the facility out to the smoking area to smoke and tell them not to smoke in the facility. - Staff were to document in the shift notes or in the resident records when a resident caught smoking. - Staff were to report it to the MA and then the Facility Manger and/or the Resident Care Coordinator would be notified. - The Resident Care Coordinator would then review the smoking policy with the resident caught to ensure they understand. - They do not take away smoking materials but the facility had the right to confiscate smoking materials. - She then said the MA would give residents 4 -5 cigarettes and light the cigarette as needed on each shift. - The facility did not have a policy for discharge if residents continued to smoke in the building. - There had been a history of other consequences but they did not work out. - She did not know staff were not documenting the smoking incidents. - She did not keep documentation of resident behaviors, monitoring for supervision and counseling for the instances of smoking nor any consequences for the behaviors given. <p>Review of facility shift notes where staff were to document smoking incidents revealed:</p> <ul style="list-style-type: none"> - There were no shift notes provided for April 2015 after requested. - Shift notes for June 2015 did not reveal any documentation of smoking in the building. <p>Review of the facility's House Rules for Use of</p>	{D 270}		6-8-15
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{D 270}	<p>Continued From page 25</p> <p>Smoking revealed:</p> <ul style="list-style-type: none"> - 1. Residents who smoke must use the designated smoking areas outside of the building. - 2. No smoking is allowed in resident rooms. - 3. Staff will supervise residents who smoke. - The home reserves the rights to confiscate all smoking materials if the resident fails to abide by smoking policies so as to insure fires safety for themselves and other residents. <hr/> <p>Review of the facility's Plan of Protection dated 6/05/15 included:</p> <ul style="list-style-type: none"> - The facility would immediately implement a facility security check list of rooms every 15 minutes with documentation of every resident known to be on the smoking list. - If caught smoking in room, smoking materials will be confiscated. - The facility manager will be notified of infractions of the rule and would come to the facility over the weekend to talk with residents caught smoking. - Staff will give cigarettes or smoking materials in the smoking area. - Staff will stay with smokers until they finish smoking. - The Medication Aide will communicate with Resident Care Coordinator and Facility Manager if someone is caught smoking in the facility. - The Facility manager will check the security check logs daily. - Meeting will be set up for all smokers to stress the warning and consequences of smoking in the facility. - The smoking policy will be revised. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 20,</p>	{D 270}		6-8-15

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{D 270}	Continued From page 26 2015.	{D 270}		
{D 273}	<p>10A NCAC 13F .0902(b) Health Care</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: FOLLOW-UP TO TYPE A2 VIOLATION</p> <p>The Type A2 Violation was abated. Non-compliance continues.</p> <p>Based on observation, interview and record review, the facility failed to contact the primary care physician for 1 of 5 sampled Residents (#4) with blood sugars greater or equal to 350 with 23 of 58 opportunities.</p> <p>The findings are:</p> <p>Review of Resident #4's current FL-2 dated 5/13/15 revealed: -The resident's diagnoses included Type 2 Diabetes Mellitus, diabetic neuropathy and chronic renal insufficiency. -The resident had an order to check blood sugars twice daily.</p> <p>Review of the Resident Register revealed Resident #4 was admitted to the facility on 7/2/98.</p> <p>Resident #4's FL-2 dated 5/13/15 included the following medication orders:</p>	{D 273}	<p>manager Along with R.C.C. will check and monitor All Diabetes Blood sugar daily, And make sure medication Aides are docem -</p>	6-9-15

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{D 273}	<p>Continued From page 27</p> <ul style="list-style-type: none"> -Glipizide 5 milligrams (mg) give twice daily before meals (used to help control blood sugars). -An order for Lantus insulin 100 units (u) give 53 u subcutaneous (sq) at bedtime (long acting insulin used to help control blood sugars). -An order for Novolin R (Regular) Insulin use for sliding scale insulin (short acting insulin) used to help control blood sugars). If blood sugars are between 200 to 239 give 2 u; between 240 to 279 give 4 u; between 280 to 299 give 6 u; between 300 to 349 give 8 u; call the primary care physician if the blood sugars are 350 and give 8 u; if greater than 450 go to the emergency room (ER). <p>Review of Resident #4's April 2015 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> -There was documentation of the above sliding scale with the time, site and units given. -"Lantus 100 u inject 53 u at bedtime sq, increase Lantus 1-2 u at night each day until the morning glucose is stable 100-130" was transcribed on the MAR. <p>Review of Resident #4's 8:00 a.m. (before breakfast) April 2015 blood sugar log revealed:</p> <ul style="list-style-type: none"> -From 4/8/15-4/30/15, the resident's blood sugars ranged from 191-381. -On 4/10/15 and 4/12/15, the resident refused to have the blood sugars taken. -On 4/15/15, the resident's blood sugar was 355. There was no documentation the resident's primary care physician was notified. -On 4/20/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. <p>Review of Resident #4's 4:00 p.m. (before supper) April 2015 blood sugar log revealed:</p> <ul style="list-style-type: none"> -From 4/8/15-4/30/15, the resident's blood sugars 	{D 273}	<p>ting, And Also calling, or Faxing the Doctors, and getting A response's and will Also do the same for Blood pressure's.</p> 	<p>6-9-15</p>
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 8100 DUNN ROAD WADE, NC 28395
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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
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{D 273}	<p>Continued From page 28</p> <p>ranged from 214-464.</p> <p>-On 4/16/15, the resident refused to have blood sugars taken.</p> <p>-There was no documentation of the blood sugars taken on 4/28/15.</p> <p>-On 4/12/15, the resident's blood sugar was 424. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/13/15, the resident's blood sugar was 449. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/14/15, the resident's blood sugar was 472. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/16/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/20/15, the resident's blood sugar was 421. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/21/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/23/15, the resident's blood sugar was 395. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/25/15, the resident's blood sugar was 360. There was no documentation the resident's primary care physician was notified.</p> <p>-On 4/29/15, the resident's blood sugar was 364. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's May 2015 MAR revealed:</p> <p>-There was documentation of the blood sugars from 5/10/15-5/30/15.</p> <p>-There was documentation of the sliding scale with the time, site and units given.</p> <p>-Lantus 100 u inject 53 u at bedtime sq, increase</p>	{D 273}		6-9-15
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{D 273}	<p>Continued From page 29</p> <p>Lantus 1 u at night each day until the morning glucose is stable 100-130" was transcribed on the MAR.</p> <p>Review of Resident #4's May 2015 blood sugar log revealed: -From 5/1/15-5/19/15, the 8:00 a.m. blood sugars ranged from 153-355. The resident refused to have the blood sugar taken on 5/5/15. -From 5/1/15-5/19/15, the 4:00 p.m. blood sugars ranged from 260-460. The resident refused to have the blood sugar taken on 5/16/15.</p> <p>Review of a facility fax sheet attached to the May 2015 blood sugar log revealed the blood sugars from 5/1/15-5/19/15 was faxed to the primary care physician on 5/20/15.</p> <p>Review of Resident #4's primary care physicians' orders revealed: -An order dated 8/28/14 revealed to give the resident 28 u of Lanutus insulin sq at bedtime. -A subsequent order dated 10/9/14 revealed to give the resident 32 u of Lantus insulin at bedtime. May increase Lantus insulin 1 u nightly until am blood sugar is "around 120-130." -A subsequent order dated 5/12/15 revealed to increase Lantus insulin 1 units at night daily until the am glucose is stable around 120-130. -A current order dated 5/20/15 to increase Lantus insulin to 58 u. Increase Lantus insulin 1 u daily until am glucose "is around 120-130. Please continue on Regular insulin for sliding scale."</p> <p>Review of Resident #4's progress notes dated 5/19/15 revealed: -The resident's primary care physician was contacted. -The resident's blood sugars ranged between 300-400.</p>	{D 273}		6-9-15

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{D 273}	<p>Continued From page 30</p> <ul style="list-style-type: none"> -The resident is up to 55 u of Lantus plus coverage. -The resident refused to go to the emergency room on 5/19/15. <p>Review of Resident #4's 8:00 a.m. May 2015 blood sugar log from 5/20/15-5/31/15 revealed:</p> <ul style="list-style-type: none"> -The blood sugars ranged from 111-429. -On 5/20/15, the resident was out of the facility. -On 5/31/15, the resident refused to have the blood sugars taken. -On 5/21/15, the resident's blood sugar was 365. There was no documentation the resident's primary care physician was notified. -On 5/26/15, the resident's blood sugar was 408. -On 5/29/15, the resident's blood sugar was 429. There was no documentation the resident's primary care physician was notified. <p>Review of Resident #4's 4:00 p.m. May 2015 blood sugar log from 5/20/15-5/31/15 revealed:</p> <ul style="list-style-type: none"> -The blood sugars ranged from 214-464. -On 5/20/15, the resident's blood sugar was 405. There was no documentation the resident's primary care physician was notified. -On 5/21/15, the resident's blood sugar was 350. There was no documentation the resident's primary care physician was notified. There was no documentation the resident's primary care physician was notified. -On 5/22/15, the resident's blood sugar was 372. There was no documentation the resident's primary care physician was notified. -On 5/23/15, the resident's blood sugar was 464. The blood sugar was rechecked at 8 p.m. and was 324. There was no documentation if the resident's primary care physician was notified or if the resident was sent to the ER. - On 5/27/15, the resident's blood sugar was 413. There was no documentation the resident's 	{D 273}		6-9-15

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{D 273}	<p>Continued From page 31</p> <p>primary care physician was notified.</p> <p>-On 5/28/15, the resident's blood sugar was 454. There was no documentation the resident's primary care physician was notified or if the resident was sent to the ER.</p> <p>-On 5/30/15, the resident's blood sugar was 404. There was no documentation the resident's primary care physician was notified.</p> <p>-On 5/31/15, the resident's blood sugar was 354. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's progress note entry dated 5/26/15 at 5:00 p.m. documented by staff revealed:</p> <p>-The resident's primary care physician revealed to give the resident 59 u of Lantus insulin on 5/26/15 and increase 1 u of Lantus insulin nightly until the resident's glucose is between 120-130 in the am.</p> <p>-If the resident received up to 100 u of Lantus, it would be fine, because the physician was trying to find a dose of Lantus insulin, which would work for the resident.</p> <p>-Notify the physician if there are any changes in the blood sugars.</p> <p>-If the resident received up to 100 u of Lantus insulin it would be fine. The physician was trying to find a night dose of Lantus, which is why he requested the facility to increase the insulin 1 u each night until blood sugars ranged from 120-130.</p> <p>Review of Resident #4's June 2015 MAR revealed:</p> <p>-There was documentation of the sliding scale with the time, site and units given:</p> <p>-"Lantus 100 u inject 58 u at bedtime sq, increase Lantus 1 u at night each day until the morning glucose is stable 120-130" was transcribed on the MAR.</p>	{D 273}		20-9-15
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{D 273}	<p>Continued From page 32</p> <p>Review of Resident #4's 8:00 a.m. June 2015 blood sugar log from 6/1/15-6/3/15 revealed: -The resident refused to have the blood sugars taken on 6/1/15. -On 6/2/15, the resident's blood sugar was 300. -On 6/3/15, the resident's blood sugar was 373. There was no documentation the resident's primary care physician was notified.</p> <p>Review of Resident #4's 4:00 p.m. June 2015 blood sugar log from 6/1/15-6/2/15 revealed: -On 6/1/15, the resident's blood sugar was 331. -On 6/2/15, the resident's blood sugar was 360. The resident's primary care physician was notified.</p> <p>Interview with a Medication Aide (MA) on 6/3/15 at 10:45 a.m. revealed: -Resident #4 had an order to contact the primary care physician if the sugar is 350 and to give 8 u of insulin. If the blood sugar is 450 and above to give 8 u of insulin and send to the ER. -The Lantus insulin is increased 1 u nightly if the a.m. blood sugars are not between a certain range. -Resident #4's blood sugars are 350 and above 3-4 days weekly. -Sometimes Resident #4 refused to go to the ER or physician's office. The physician just said to monitor the blood sugars. -The MA had not always contacted the Resident #4's primary care physician when the blood sugars were 350 and above or sent the resident to the ER when the blood sugars were 450 and above. -On 5/27/15, Resident #4's a.m. blood sugar was 368. He gave the resident 8 u of insulin. -He rechecked the resident's blood sugar 15 minutes later and contacted the physician.</p>	{D 273}		6-9-15
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{D 273}	<p>Continued From page 33</p> <ul style="list-style-type: none"> -He could not provide documentation of contacting the physician. <p>Interview with another MA on 6/5/15 at 3:15 p.m. revealed:</p> <ul style="list-style-type: none"> -When Resident #4's blood sugars were 350 and above or 450 and above, he did not contact the resident's physician. -He should have contacted Resident #4's physician when the blood sugars were out of range. -There was no excuse to why he did not contact Resident #4's physician. <p>Interview with the Resident Care Coordinator (RCC) on 6/5/15 at 2:47 p.m. revealed:</p> <ul style="list-style-type: none"> -The RCC supervised the MAs -The MA should fax the physician when needed. -Weekdays, the MA will inform the RCC when they have faxed the resident's physician. -Resident #4's primary care physician responded better via fax. -She did not check blood sugar logs to make sure the MA's contacted the physician when the blood sugars were in a certain range. -She only checked the fax to make sure it was received by the resident's primary care physician. <p>Interview with the facility Manager on 6/5/15 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> -The MA and RCC should contact Resident #4's primary care physician when the blood sugars are out of range. -If the RCC or MA cannot fax the resident's physician, inform the Manager and she would try to fax the resident's physician. -The RCC should check the blood sugar logs three times weekly to make sure MA's are contacting the resident's primary care physicians when needed. 	{D 273}		6-9-15
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{D 273}	<p>Continued From page 34</p> <p>-She was not aware the RCC had not been checking the blood sugar logs to make sure staff are contacting the resident's physician as ordered.</p> <p>-She was notified on 6/5/15 Resident #4's primary care physician would no longer be working at the company.</p> <p>Resident #4 had to come to the care provider's office to be re-evaluated by another physician.</p> <p>Resident #4's primary care physician could not be reached by the end of the survey.</p> <p>The Administrator was not available for interview.</p>	{D 273}	↓	6-9-15
{D 338}	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, were maintained and exercised without hindrance.</p> <p>The findings are:</p> <p>Cross refer to Tag D911, G.S. 131D-21(1) Declaration of Residents' Rights.</p> <p>Based on observation and interview, the facility failed to assure 2 of 2 residents were treated with respect, consideration, dignity and full recognition</p>	{D 338}	↓	7-16-15

Maintenance will replace Blood 14 -

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{D 338}	Continued From page 35 of individuality and right to privacy by not providing curtains, draperies or blinds in a shared room.	{D 338}	Residents Room and secure the cord so he will not be able to pull it down.	7-6-15
{D911}	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observation and interview, the facility failed to assure 2 of 2 residents were treated with respect, consideration, dignity and full recognition of individuality and right to privacy by not providing curtains, draperies or blinds in a shared room. The findings are: Observation of room #205 on 6/5/15 1:15pm revealed no curtains or blinds covering the large window of the room. One confidential resident interview revealed: -There had not been blinds in room #205 as long as this staff could remember. One confidential staff interview revealed: -There had been blinds a month ago in room	{D911}		

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{D911}	<p>Continued From page 36</p> <p>#205.</p> <ul style="list-style-type: none"> -Every time someone put up new blinds the resident would grab the blinds by the cord or jerk the blinds anyway possible. -Staff were afraid the blinds being pulled down like that would possibly hurt the 2 residents in the room. -Staff had mentioned this to management. -Staff was told there was no use putting up blinds because the resident would pull them down. -The resident that pulled the blinds down required changing of incontinent pads. <p>Interview with the facility manager on 6/5/15 at 6:15pm revealed:</p> <ul style="list-style-type: none"> -There had been 6 sets of blinds put up in room #205. -The resident will snatch the blinds down anyway he can. -She had mentioned to the maintenance man about some way to secure the pull cords of the blinds. -The maintenance man was very busy. -She did not believe the owner was aware of the missing blinds. <p>The maintenance man could not be reached by the end of the survey.</p> <p>The Administrator was not available for interview.</p>	{D911}		7-6-15
{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:</p> <p>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p>	{D912}		

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{D912}	Continued From page 37 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to residents smoking inside the facility. The findings are: Based on observation, interview and record review, the facility failed to assure 5 of 5 sampled residents did not smoke in the facility. (# 2, #6, # 7, # 8, # 9). [Refer to Tag D270, 10A NCAC 13F .0901(b). (Type B Violation)]	{D912}		
{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	{D992}	The Facility now has a sign contract with a company to do our pre-employment drug testing.	6-18-15

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{D992}	<p>Continued From page 38</p> <p>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: Based on interviews and record reviews, the facility failed to require an examination and screening for the presence of controlled substances required for applicants for employment in adult care homes for 3 of 3 sampled staff. (B, E, G).</p> <p>The findings are:</p> <p>A. Review of Staff B's personnel record revealed: -The hire date was 4/15/15. -No documentation of a drug screen.</p> <p>Interview with Staff B on 6/5/15 at 12:55pm revealed: -No drug screen was required upon hire. -She could not recall if she had been told a drug screen would be required in the future.</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p>	{D992}	<p>for newly hired Employees. It was obtain by the owner.</p>	<p>6-18-15</p>
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{D992}	<p>Continued From page 39</p> <p>B. Review of Staff E's personnel record revealed: -The hire date was 11/1/13. -No documentation of a drug screen.</p> <p>Staff E was not available for interview.</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>C. Review of Staff G's personnel record revealed: -The hire date was 5/11/15. -No documentation of a drug screen.</p> <p>Staff G was not available for interview.</p> <p>Refer to interview with the facility Manager on 6/5/15 at 12:55am.</p> <p>Interview with the facility Manager on 6/5/15 at 12:55am revealed: -The facility did not require drug screens upon hire. -The owner had communicated he was going to contract a company to provide that service but nothing had been done about it. -She was aware of the rule requirement. -The owner was aware of the rule requirement from the last survey.</p> <p>The Administrator was not available for interview.</p>	{D992}		6-18-15

Addendum:

Telephone interview with the Facility Manager on 9/24/15 at 10:57 am revealed:

- She would ^{get} lamps for all of the residents who did not have ~~to~~ ^{to} a lamp in their room. All of the residents would have a lamp by 10/9/15. (Housekeeping + Furnishings .0306 (b)(8))

- The medication aide ^(cust) will contact the resident's MD based on the parameters for vital signs. The MD will be contacted via fax ^{the same day}. If the MD does not receive a response from the PCP the PO or Manager will contact the PCP. If a ~~resident's~~ resident has abnormal behaviors, the resident's mental health provider will ~~be contacted~~ ^{be contacted} the same day. If a resident is refusing treatments, the resident's PCP will be contacted the same day. [Health Care Referral - 0811 .0102 (b)]

- The Facility Manager will make sure there is documentation of staff drug screening in the personnel files. She will check staff personnel files 1-24/15 to make sure staff have all ^{is} ~~required~~ requirements and training in the files.

- The date of correction for ^{the rule area} Housekeeping + Furnishings .0306 (b)(8) is 10/9/15. The date of correction for all of the other rule areas in the SOS is 6/6/15.

9/24/15

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