

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL014002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2016
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NAME OF PROVIDER OR SUPPLIER CAROLINA OAKS ENHANCED CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 229 WILSON STREET NW LENOIR, NC 28645
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D 000	Initial Comments Surveyor: NC447 The Adult Care Licensure Section and the Caldwell County Department of Social Services conducted an annual survey on June 1 - 2, 2016.	D 000		
D 072	10A NCAC 13F .0305(m) Physical Environment 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. This Rule is not met as evidenced by: Surveyor: NC412 Based on observation and interview the facility failed to maintain the gutter along the front of the facility in a clean and safe condition. The findings are: Observation of the gutter along the front of the facility on 6/1/16 at 9:15am revealed the gutter was filled with debris and tree sprouts visible when standing on the ground. Interview with a maintenance staff on 6/2/16 at 11:30am revealed: -He was sub-contracted by the facility to provide maintenance at the facility. -He received a faxed list of maintenance issues "about every other day".	D 072		

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

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D 072	<p>Continued From page 1</p> <ul style="list-style-type: none"> -When at the facility he would conduct a "walk-through" and document other maintenance issues that needed attention. -Staff could call him directly if there was an emergency maintenance issue. <p>Interview with the Administrator and Administrator-in-Training (AIT) on 6/2/16 at 3:15pm revealed:</p> <ul style="list-style-type: none"> -Staff are to report any maintenance issues to the supervisor. -The supervisor completed a form. -The form was faxed to the sub-contracting company that provided maintenance services at the facility. -The sub-contracting company scheduled the repairs with one of their maintenance employees. -If there was a maintenance emergency, such as a broken water pipe, staff would call the maintenance sub-contractor directly or staff would call the AIT. -The AIT is always on-call. -The condition of the gutters were discussed today. 	D 072		
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: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: Surveyor: NC412 Based on observation, interview and record review, the facility failed to make repairs to, or</p>	D 074		

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D 074	<p>Continued From page 2</p> <p>maintain in clean condition floors, walls, ceilings, doors and light fixtures throughout the facility.</p> <p>The findings are:</p> <p>Observations of the facility on 6/1/16 and 6/2/16 revealed:</p> <ul style="list-style-type: none"> -In the common bathroom on the left across from the dining room entrance on the middle hallway, the caulking around the handwashing sink was discolored, chipped and pulling away from the sink. The exhaust fan cover had a visible layer of dust. -There was a broken cover plate on the 2-plug outlet on the front hall wall to the left of the medication room/office. -In the dining room on the outside facing wall, to the right, the baseboard heater cover was dislodged and hanging down. The eight fluorescent lamp safety sleeves showed a layer of dust along the top of the bulb. -The handrails on the stairs going to the upstairs resident area were rough to the touch, areas of chipped or missing paint and one section had been pushed inward towards the wall (appeared someone may have bumped into the railing and dislodged it). -In the upstairs common bathroom accessed from the living room there was a substance that appeared to be mold or dirt on the caulk around the bathtub and the area where the shower door was attached to the tub. The ceiling exhaust fan was hanging loose on one side. The clear plastic shower safety mat appeared to have a rust colored water stain. -In the upstairs porch smoking area there were 11 kitchen type chairs. All of the chairs seats were torn, exposing the padding material. There was a damaged 3-drawer bedside table on the porch outside of the door leading to the smoking area. 	D 074		

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D 074	<p>Continued From page 3</p> <p>There was a living room type upholstered chair that was stained and torn from use over most of the upholstering.</p> <ul style="list-style-type: none"> -In the upstairs common bathroom between rooms 27 and 29 there was a brown substance on the wall behind the toilet paper dispenser. The linoleum floor where it met the walls and bathtub was curled-up and pulled away from the floor. Along the base of the handwashing sink vanity, the baseboard molding was pulled away from the vanity and paint was chipped on the side of the vanity. The clear plastic shower safety mat appeared to have a rust colored water stain. The exhaust fan cover was rusted. -The fluorescent light cover on the upstairs hallway adjacent to rooms 24 and 25 was missing. -In room 27 the baseboard heater cover was hanging loose and dislodged. There were hairline cracks in the floor tile in the center of the room. The arm rests, back and seat cushion of the upholstered living room chair was stained and dirty from use. -In room 25, the arm rests and seat cushion of the upholstered living room chair was stained and dirty from use. -The baseboard heater cover between rooms 17 and 18 was dislodged. -In the common bathroom on the middle hallway next to room 15, the cover plate over the 2-prong outlet was bent almost in half and protruded out from the wall. -The safety handrail on the wall next to the commode in the shower room across from the dining room in the middle hallway was loose. The porcelain/ceramic corners of the handwashing sink were chipped, scuffed and worn. <p>Observation of Personal Care Aide (PCA) on 6/1/16 at 11:00am revealed staff cleaned the</p>	D 074		

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D 074	<p>Continued From page 4</p> <p>brown substance on the wall behind the toilet paper dispenser in the upstairs common bathroom between rooms 27 and 29.</p> <p>Observation of housekeeping staff on 6/1/16 at 12:45pm revealed staff were replacing the broken cover plate on the 2-plug outlet on the front hall wall to the left of the medication room/office.</p> <p>Observation and interview with a resident on 6/2/16 at 3:00pm revealed: -The resident was sitting on a chair on the upstairs porch smoking area. -The resident told the Administrator-in-Training (AIT) new furniture was needed for the smoking area.</p> <p>Observation of ceiling in Room 22 on 6/1/16 at 10:20am revealed an attic door in corner of ceiling that was falling down (could see into the attic) and molding that was coming apart from walls/attic opening.</p> <p>Interview with Resident in Room 22 on 6/1/16 at 10:20am revealed: -The ceiling had been this way since he moved into this room. -He had lived in the room for about 3-4 months. -It did not bother him.</p> <p>Observation of common half bathroom on the middle hallway on 6/1/16 at 10:41am revealed: -Ceiling light fixture was missing the cover. -Large brown stains on 3 ceiling tiles above toilet. -Vent above toilet was covered in dust.</p> <p>Interview with a resident on 6/1/16 at 12:00pm revealed the common toilet room (small room with toilet only) on the middle hallway did not have a lock on the door.</p>	D 074		

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D 074	<p>Continued From page 5</p> <p>Interview with a maintenance staff on 6/2/16 at 11:30am revealed: -He was sub-contracted by the facility to provide maintenance at the facility. -He received a faxed list of maintenance issues "about every other day". -When at the facility he would conduct a "walk-through" and document other maintenance issues that needed attention. -Staff could call him directly if there was an emergency maintenance issue.</p> <p>Interview with the Administrator and AIT on 6/2/16 at 3:15pm revealed: -A lock had been installed on the door to the common toilet room on the middle hallway. -Staff are to report any maintenance issues to the supervisor. -The supervisor completed a form. -The form was faxed to the sub-contracting company that provided maintenance services at the facility. -The sub-contracting company scheduled the repairs with one of their maintenance employees. -If there was a maintenance emergency, such as a broken water pipe, staff would call the maintenance sub-contractor directly or staff would call the AIT. -The AIT is always on-call.</p> <p>Review of facility's County Health Department building inspection dated 6/22/15 revealed: -Four points were deducted under the floors, walls and ceilings heading. -Comments were damage to floors in many rooms and common bath upstairs. Floors should be kept clean and in good repair. Several hall ceilings were dusty in the vicinity of hall fans. Walls and ceilings should be clean and in good</p>	D 074		

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D 074	Continued From page 6 repair. -A documented score of 91.	D 074		
D 287	<p>10A NCAC 13F .0904(b)(2) Nutrition And Food Service</p> <p>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.</p> <p>This Rule is not met as evidenced by: Surveyor: NC412 Based on observations, interviews, and record reviews, the facility failed to assure the place setting for all residents included a knife, fork, and spoon without an assessment of each resident and exceptions made on an individual basis.</p> <p>The findings are:</p> <p>Observation of dining room place settings on 6/1/16 at 11:30am, 6/2/16 at 8:30am and 6/2/16 at 11:50am revealed: -All place settings at all tables included a paper napkin, metal fork, and a metal spoon. -None of the place settings included a table knife.</p> <p>Observation of lunch on 6/1/16 at 11:30am, breakfast on 6/2/16 at 8:30am and lunch on 6/2/16 at 11:50am revealed none of the served food needed to be cut with a knife.</p>	D 287		

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D 287	<p>Continued From page 7</p> <p>Observation of the locked food service storage area on 6/2/16 at 11:00am revealed 2-32 count boxes of dinner knives.</p> <p>Interview with 11 residents on 6/1/16 and 6/2/16 revealed: -Nine stated that knives were not provided at mealtimes. -Four stated that they would prefer to use a knife to cut foods at mealtimes. -Five stated that the staff assisted residents with cutting foods, as needed. -One stated he did not want a knife even if offered one from staff. He used the fork and spoon to cut his food. Sometimes it could be a problem not having a knife when he needed to cut meats. -Another resident stated not having a knife was "not a problem". He did not know if he could get a knife if he asked staff for one. -One stated he did not receive a knife at mealtimes and that was not a problem. He used a fork to cut his food.</p> <p>Interview with a kitchen staff on 6/1/16 at 12:10pm and 6/2/16 at 11:10am revealed: -Knives are not given out at mealtimes, "they get gone". -Staff will provide a resident with a knife if they asked for one. -Some residents ask the kitchen staff to cut their food. -Staff used to wrap a spoon, fork and knife in a paper napkin. When residents emptied their plates the knives remained wrapped up in the napkin and they would get thrown away.</p> <p>Interview with a second kitchen staff on 6/2/16 at 10:45am revealed:</p>	D 287		

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D 287	<p>Continued From page 8</p> <p>-She knew the residents who wanted the staff to cut their food.</p> <p>-There are other residents who would ask when they wanted their food cut and some residents don't want staff to cut their food.</p> <p>Interview with three staff on 6/2/16 revealed: -"Don't use knives for safety reasons, the residents don't ever ask for it or complain about not having them." -"They never have knives for safety reasons." -"Only use knives if needed for meats." -"If they ask for a knife we will give it to them."</p> <p>Interview with the Administrator on 6/2/16 at 3:15pm revealed: -Providing knives at mealtimes used to be a problem in the past to due previous resident's mental health issues. There were some who were easily agitated, liked to argue. "Seemed like there was one or two who wanted to keep things stirred up" so providing a knife at mealtimes was a safety issue. -She was not aware there were 2 boxes of knives in storage. -She indicated they would start providing residents with a knife.</p>	D 287		
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: Surveyor: NC412</p>	D 338		

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D 338	<p>Continued From page 9</p> <p>Based on observation, interview and record review, the facility failed to offer residents who ate first a second helping of food until after the second seating of residents completed their meal.</p> <p>The findings are:</p> <p>Observation of daily census form on 6/1/16 revealed 41 residents residing at the facility.</p> <p>Review of resident information cards used in the kitchen on 6/2/16 revealed 24 residents were in the first seating.</p> <p>Observation of lunch on 6/1/16 at 11:30am, breakfast on 6/2/16 at 8:30am and lunch on 6/2/16 at 11:50am revealed:</p> <ul style="list-style-type: none"> -There were eight tables with room for four chairs per table in the dining room. -Meals were served to the residents in two separate seatings. -Following the first seating, staff cleaned the tables and prepared them for the second seating of residents. <p>Observation of lunch on 6/2/16 at 12:45pm revealed:</p> <ul style="list-style-type: none"> -First and second diners had finished eating. -There were six residents being served a second helping of the lunch meal. <p>Interview with eight residents on 6/1/16 and 6/2/16 revealed:</p> <ul style="list-style-type: none"> -All eight residents ate at the first seating. -Residents stated that "first diners" who requested second helpings at mealtimes, were told to return to the dining room after the "second diners" had finished their meals. -One resident stated he was "okay" with waiting, he waited until everyone was fed then would go 	D 338		

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D 338	<p>Continued From page 10</p> <p>back for seconds.</p> <p>Interview with a kitchen staff on 6/1/16 at 12:02pm revealed: -If residents who were "first diners" requested second helpings at mealtimes, they were told to return to the dining room after the "second diners" had finished their meal. -If residents who were on a special diet request second helpings at mealtimes, they were given foods that were appropriate according to their diet orders.</p> <p>Interview with a second kitchen staff on 6/2/16 at 10:45am revealed when first and second seatings had finished eating, residents who wanted a second helping would be served.</p> <p>Interview with a Personal Care Aide on 6/2/16 at 3:12pm revealed: -They told all residents to wait until after 2nd lunch is completed to come back for seconds. -There were only three residents that she was aware of that wanted seconds.</p> <p>Interview with the Administrator on 6/2/16 at 3:15pm revealed: -She was not aware residents who had their meal during the first seating were not offered or provided a second helping until after the second seating had completed their meal. -She knew of some residents who received "a bit extra" (of food) because staff knew they would ask for seconds. -She would address the issue with the kitchen staff and start serving seconds to residents who ate during the first seating.</p>	D 338		