

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL046018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
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NAME OF PROVIDER OR SUPPLIER TWIN OAKS AND TWINS ADULT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE BLDG # 817 HIGHWAY 258 NORTH COMO, NC 27818
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on June 7-9, 2016.	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 observations and interviews, the facility failed to assure the back patio furniture and the screened outside storage area was maintained in a clean and safe condition.</p> <p>The findings are:</p> <p>Observation of the back patio furniture on 6/9/16 at 1:45 p.m. revealed: -Two chairs with plastic coverings, metal arm rests and legs, three chairs with vinyl coverings wooden arm rests and legs and a two seated vinyl sofa were on the back patio. -The two with plastic coverings and metal arm rests and legs had black dried substance on the front, back sides and leg of the chairs. The metal arm rests and legs had peeled paint. -The three vinyl chairs and the vinyl sofa had black dried substance on the front, back sides and legs of the chairs and sofa.</p>	D 072		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 072	<p>Continued From page 1</p> <p>Observation of the half screened storage area on 6/9/16 at 1:45 p.m. revealed:</p> <ul style="list-style-type: none"> -The front and half of both sides of the storage area was screened in. One fourth of the storage area had metal siding. -The bottom of the entrance door had metal siding loosened from the door and the metal siding around the storage area was loosed. -Two bricks on top of a can kept the screened door closed. -The wood around the screened door had chipped paint. -The inside of the storage area included several filing cabinets and chairs. <p>Observation on 6/8/16 at 12:42 p.m. revealed two residents were sitting outside on the back patio in the patio chairs.</p> <p>Interview with one of the residents, who was sitting on the back patio on, on 6/8/16 at 12:43 p.m. revealed the resident did not have a problem with the cleanliness of the furniture on the back patio.</p> <p>Interview with a second resident on 6/9/16 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> -Sometimes the resident went outside and sat on the back patio. -The resident did not have a problem with the cleanliness of the patio furniture. <p>Interview with a Personal Care Aide on 06/08/16 at 4:40 p.m. revealed:</p> <ul style="list-style-type: none"> -Cleaning of the furniture and back porch was supposed to be done by all the staff at the facility. -She does not know the last time the furniture on the back patio was cleaned. <p>Interview with the Co-Administrator on 06/09/16</p>	D 072		

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D 072	<p>Continued From page 2</p> <p>at 11:40 a.m. revealed:</p> <ul style="list-style-type: none"> -The cleaning of the back patio and its furniture was to be cleaned by all staff daily. -The chairs on the back patio should be wiped down and cleaned every day. -She was not sure the last time chairs on the patio were cleaned. -She knew the chairs on the back patio needed to be thrown away. -The facility had brought new chairs for the back patio and placed them in the storage outside. <p>Interview with the Co-Administrator on 06/09/16 at 1:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The facility had brought 9 plastic green chairs to replace the old chairs on the back patio within the last month. -The facility had not replaced the chairs yet because they needed to have someone to remove the old chairs and bring the new chairs out of the storage area. -The staff would be responsible for making sure the new outside chairs were cleaned daily. -The outside storage area was going to be cleaned up so the residents could have another area to sit out in the yard. <p>Interview with a third resident on 06/09/16 at 2:05 p.m. revealed:</p> <ul style="list-style-type: none"> -The old chairs on the back patio had been there for at least 2 years. -She never saw staff wipe down the furniture on the back patio. -She didn't like to sit on the chairs on the back patio sometimes because they were dirty. -She had not complained to staff about the cleanliness of the chairs on the back patio. -She knew the facility had new chairs to replace the old chairs on the back patio. -She sweep the back patio almost every day. 	D 072		

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D 072	<p>Continued From page 3</p> <p>-She was not sure when she last saw any staff sweep the back patio.</p> <p>Interview with the Administrator on 6/09/16 at 2:39 p.m. revealed:</p> <p>-The residents go on the back porch (patio) and sit.</p> <p>-Staff had tried to wash the black stains off the patio furniture, but it would not come off.</p> <p>-She did not know when the patio furniture was last cleaned.</p> <p>-She has had the back patio furniture on the back porch at least since January 2016.</p> <p>-She wish she could get some new furniture, but she could not buy it.</p> <p>-The outside storage area will be accessible to resident.</p> <p>-The metal vinyl on the outside screened in storage area will be fixed before they allow residents to use it.</p> <p>-The residents last used the storage area to sit during the summer of 2015, which was before the facility started using it as a storage area.</p> <p>-The residents had not complained of patio furniture or the outside storage area.</p>	D 072		
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> <p>(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: Based on observations and interviews, the facility failed to assure the floors, walls and floor</p>	D 074		

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D 074	<p>Continued From page 4</p> <p>coverings in the resident's rooms, bathrooms and living room were cleaned and in good repair.</p> <p>The findings are:</p> <p>Observations of the main hallway for the facility on 06/07/16 at 1:25 p.m. revealed:</p> <ul style="list-style-type: none"> -All of the base baseboards along the entire hallway had black and brown stains with brown dust. -Floors in the hallway had several brown stains. -Buildup of dark brown dust was in 20 of 20 corners of the doorways. <p>Observations of Room 1 on 06/07/16 at 1:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Four of four walls had several areas of black and brown scuff marks. -Four of four baseboards had dark brown and black stains with brown dust. -The floor had several areas of black and brown stains. <p>Observations of Room 17 on 06/07/16 at 1:32 p.m. revealed:</p> <ul style="list-style-type: none"> -Four of four walls had several areas of black and brown scuff marks. -Four of four baseboards had dark brown and black stains with brown dust. -There was an area of chipped peeling paint on the right wall adjacent to the door. -There were black marks to the lower wall next to the closet door. -The floor had a large brown stain at the entranceway of Room 17. <p>Observations of Room 2 on 06/07/16 at 1:35 p.m. revealed:</p> <ul style="list-style-type: none"> -Three of four walls had several areas of black and brown scuff marks. 	D 074		

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D 074	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Four of four baseboards had dark brown and black stains with brown dust. -A scraped area on the wall behind the door measured 1 foot long and ¾ of an inch wide. -Two areas of peeling paint were on the wall around the light switch. <p>Observations of Room 18 on 06/07/16 at 1:37 p.m. revealed:</p> <ul style="list-style-type: none"> -Four of four walls had several areas of black and brown scuff marks. -Four of four baseboards had dark brown and black stains with brown dust. -An area of scraped and peeling paint was in the middle of the behind to the television on the right side of the room. -The floor had several areas of black and brown stains. <p>Interview with a Personal Care Aide on 06/08/16 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The Personal Care Aides were responsible for sweeping and mopping the floors in the residents' rooms and bathrooms. -The Personal Care Aides wiped down the walls and baseboards in the residents rooms and bathrooms when the Administrator or Co-Administrator told them to do so. -There was no cleaning schedule for the Personal Care Aides to follow. -Cleaning the facility was done as it was needed or when it was assigned. -The walls needed to be painted and the Administrator and Co-Administrator were responsible for calling the painter to do touch up painting. -Any needed repairs, she wrote on a piece of paper and gave to the Co-Administrator or the Administrator. -She did not remember when she told the 	D 074		

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D 074	<p>Continued From page 6</p> <p>Co-Administrator or Administrator about the walls that needed painting.</p> <p>Interview with a second Personal Care Aide on 06/08/16 at 4:40 p.m. revealed:</p> <ul style="list-style-type: none"> -The Personal Care Aides were responsible for cleaning the floors and walls in the facility. -The Co-Administrator and Administrator helped with cleaning the facility too. -There was no cleaning schedule for the Personal Care Aides to follow. -All staff were supposed to assist with maintaining the cleanliness of the facility. -The Personal Care Aides who worked the day shift made the residents' beds, cleaned the residents' rooms, swept the floors in the residents' rooms, and cleaned walls and baseboards in the residents' rooms. -The Personal Care Aides who worked the night shift cleaned the main hallway floors and baseboards, and cleaned the bathrooms. -She tried to clean and sweep the floors in the resident's room when she had the time to do it. -She wasn't sure of the last time she had cleaned the walls and baseboards in the residents' room or when the floors or baseboards in the main hallway had been done. -She notified the Co-Administrator or the Administrator when repairs were needed in the facility. -She wasn't sure if she had told the Co-Administrator or Administrator about the scraped walls or any painting repairs. <p>Interview with the Co-Administrator on 06/09/16 at 11:40 a.m. revealed:</p> <ul style="list-style-type: none"> -The cleaning of the walls and the floors was the responsibility of all staff who worked at the facility. -She helped with cleaning the baseboards, walls, and floors when she saw it needed to be done. 	D 074		

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D 074	<p>Continued From page 7</p> <ul style="list-style-type: none"> -The facility did not have a cleaning schedule or cleaning checklist. -She would sometimes check behind the staff to make sure the facility was cleaned. -The staff did the best they could to take care of the residents and keep the facility clean. <p>Interview with a resident on 06/09/16 at 2:05 p.m. revealed:</p> <ul style="list-style-type: none"> -She was not happy with the cleanliness of the facility. -The facility does not have enough help to keep the facility clean as it should be. -The Administrator had hired staff who were lazy and don't keep the facility clean. -She does not remember the last time staff came in and cleaned her walls, baseboards, or floors in her room. -The Personal Care Aides did clean the floors in the bathrooms about 2-3 times per week. -She never saw any staff clean the baseboards and walls in any of the residents' rooms, bathrooms, or main hallway. <p>Observation of room #19 on 6/7/16 at 11:27 a.m. revealed:</p> <ul style="list-style-type: none"> -The middle of the floor had black stains on 12 tiles. -The floor under the head of the bed had brown and black stains. <p>Observation of room #15 on 6/7/16 at 11:28 a.m. revealed:</p> <ul style="list-style-type: none"> -The corners of the baseboards on all four walls had built-up dirt. -The lower section of the wall at the headboard had built-up brown stains. -The bedside commode between both beds had rust around the front metal and sides of the toilet. 	D 074		

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D 074	<p>Continued From page 8</p> <p>Observation of room #27 on 6/7/16 at 11:42 a.m. revealed: -Four tiles had brown rust stains, which was located between the chair and the nightstand. -One of four walls had several clear dried liquid spills.</p> <p>Observation of the handicapped bathroom on 6/7/16 at 11:50 a.m. revealed: -The shower's white floor tile and the tile on the side in the shower had built-up brown stains. -One of four walls had a black streak at the lower section of the wall and scrapped paint in the middle of the wall. -The door post on the same wall had brown and black stains. -The bottom and side of the wooden door, which led to the hall, was scraped. -The baseboards on all four walls had built-up brown and black stains. -The back of the raised plastic toilet seat had a piece of wood connected to the handles behind the raised toilet seat. -The vinyl floor tile under the toilet had two pieces of missing vinyl from around the toilet. -The tub, which was attached to the wall, had a long black stain on the inside front of the tub which led to the drainage. -Two wrapped around shower curtains, which was attached to the ceiling, was one fourth off the hinge.</p> <p>Observation of bathroom A, which was located across from room #21, on 6/7/16 at 4:02 p.m. revealed: -The baseboards on three of four walls had built-up brown dirt. -Three of four walls had scrapped paint and black stains.</p>	D 074		

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D 074	<p>Continued From page 9</p> <p>Observation of bathroom B, which was located next to bathroom A closest to the side exit door, on 6/7/16 at 4:05 p.m. revealed:</p> <ul style="list-style-type: none"> -The tub had black dirt inside. -A toilet plunger was on the inside of the tub. -The sides of the tub had brown stains. -The baseboards on all three walls had built-up brown dirt. -One of three walls had scrapped paint. <p>Observation of the living room on 6/9/16 at 12:48 p.m. revealed:</p> <ul style="list-style-type: none"> -There was a large black stain on the floor near the piano and coffee table, under the chair and between the chair and coffee table, which covered 9 tiles. -Six floor tiles, which was located between the love seat and the sofa, had brown stains . <p>Interview with a second resident on 6/8/16 at 12:43 p.m. revealed:</p> <ul style="list-style-type: none"> -The resident did not have a problem with the cleanliness of the facility. -Staff cleaned the facility daily. <p>Interview with a third resident on 6/9/16 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> -The resident had a bedside toilet so that the resident would not use the bathroom on herself. -Staff cleaned the bedside toilet weekly. -The resident did not have a problem with the cleanliness of the facility. -Staff cleaned her room and the bathrooms weekly. <p>Interview with the Administrator on 6/9/16 at 2:39 p.m. revealed:</p> <ul style="list-style-type: none"> -All of the staff cleaned the facility daily. -"Whatever needed to be cleaned, they cleaned." -The facility did not have a cleaning schedule of 	D 074		

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D 074	Continued From page 10 what should be cleaned. -Staff cleaned the facility the morning of 6/9/16. -The Co-Administrator cleaned the two bathrooms (A, B) on the hall the morning of 9/11/16. -The baseboards are cleaned as needed. -The tile in the handicapped bathroom was not repaired correctly. -They needed new shower curtains in the handicapped bathroom. -The facility was painted 5 years ago. -She could not afford to hire daily cleaning staff. -The Administrator and the Co-Administrator checked behind staff daily to make sure they have cleaned. -Staff cleaned the bedside commode once to twice daily. -The tubs and showers are cleaned daily after each use.	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 interviews and observations, the facility failed to maintain areas that were uncluttered, clean and orderly manner, free of all obstructions and hazards to the doors and residents' rooms,	D 079		

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D 079	<p>Continued From page 11</p> <p>The findings are:</p> <p>Observation of the hair dryer chair, located in the handicapped bathroom, on 6/7/16 at 11:50 a.m. revealed the right armrest had a missing arm cushion.</p> <p>Observation of the furniture in the living room on 6/9/16 at 12:48 p.m. revealed: -The chair closest to the piano had brown stains in seat cushion of the chair. -The orange chair, which was located near the front exit door, the seat cushion material was thin and worn. The seat cushion had a hole on the front right side of the chair.</p> <p>Observations of the main hallway of the facility on 06/07/16 at 1:25 p.m. revealed 20 of 20 doors had black stains, black scars, and exposed wood to the lower halves of the doors.</p> <p>Observations of Room 1 on 06/07/16 at 1:30 p.m. revealed: -A large dusty brown cobweb was in the upper left corner of the window. -The white curtain rod was bent on the left side. -Brown dust was on the window sill. -The 4-drawer brown dresser closet to the window was covered with brown dust and have several scraped areas to its top and sides. -All of the drawers of the brown dresser closet to the window were misaligned and had fallen off their tracks. -A second 4-drawer dresser next to the closet was covered with brown and white dust and had several scraped areas to its top and sides.</p> <p>Observations of Room 17 on 06/07/16 at 1:32 p.m. revealed:</p>	D 079		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	<p>Continued From page 12</p> <ul style="list-style-type: none"> -The lower half of the door frame of the entrance door had black and brown stains. -The lower third of the first closet door had black horizontal marks. -The tan blind to the window was yellowed and covered in black dust. -Several brown spots were on the lower half of the window blind. <p>Observations of Room 18 on 06/07/16 at 1:37 p.m. revealed:</p> <ul style="list-style-type: none"> -The 4 drawer black dresser was covered with brown dust and had a large white spot on the front of the 1st drawer. -The third drawer of the 4-drawer black dresser was missing the front panel and had exposed jagged wood edges to its left side. -The brown dresser next to the window was covered with brown dust and had several scraped areas on its top and sides. <p>Observation of the door frame for Room 21 on 06/07/16 at 1:40 p.m. revealed a chipped peeling paint located right below the door knob and measured approximately 4 inches long and 1 ½ inches wide.</p> <p>Interview with a Personal Care Aide on 06/08/16 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The facility did not have a housekeeping staff. -The Personal Care Aides were responsible for cleaning the residents' room and the common areas of the facility. -She dusted in the residents' room if she saw it was needed. -Any needed repairs, she wrote on a piece of paper and gave to the Co-Administrator or Administrator. -She had reported the missing dresser panel in Room 18 to the Co-Administrator but she did not 	D 079		

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D 079	<p>Continued From page 13</p> <p>remember when. -She didn't know how long the drawers to the dresser in Room 1 had been off track.</p> <p>Interview with a second Personal Care Aide on 06/08/16 at 4:40 p.m. revealed: -The Personal Care Aides were responsible for cleaning in the facility. -The Co-Administrator and Administrator helped with cleaning the facility too. -The Personal Care Aides who worked the day shift duties included cleaning the residents' rooms and dusting the furniture.</p> <p>Interview with a resident on 06/09/16 at 2:05 p.m. revealed: -She was not happy with the cleanliness of the facility. -The facility does have enough help to keep the facility clean as it should be. -The Administrator had hired staff who were lazy and don't keep the facility clean.</p> <p>Interview with the Administrator on 6/9/16 at 2:39 p.m. revealed: -The facility did not have a cleaning schedule. -Staff who worked at the facility were responsible for cleaning the dressers, nightstands, -She cannot afford to hire someone to clean the facility daily. -The Administrator and Co-Administrator checked behind staff daily for cleaning.</p>	D 079		
D 105	<p>10A NCAC 13F .0311(a) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and</p>	D 105		

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D 105	<p>Continued From page 14</p> <p>operating condition.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the refrigerator in the kitchen was maintained in safe and working condition.</p> <p>Observation of the refrigerator in the kitchen on 06/07/16 at 1:10 p.m. revealed: -The thermometer inside the refrigerator had a temperature of 54 degrees Fahrenheit. -Two gallons of milk, 1 bottle of juice, butter, cheese, Glucerna, raisins, mayonnaise, pickles, relish, and other covered food containers were in the refrigerator. -No odors were noted coming from the refrigerator -The containers in the refrigerator were cool to touch. -The food inside of the freezer side of the refrigerator was still solidly frozen.</p> <p>Observation of the refrigerator in the kitchen on 06/07/16 at 1:20 p.m. revealed: -The temperature inside of the refrigerator was 52 degrees Fahrenheit by the reading of a second thermometer. -The Co-Administrator turned the thermostat down to its coldest setting.</p> <p>Observation of the refrigerator in the kitchen on 06/07/16 at 3:20 p.m. revealed: -The temperature inside of the refrigerator was 62 degrees Fahrenheit with the refrigerator set at its coldest setting. -The food inside of the freezer side of the refrigerator was still solidly frozen. -The Co-Administrator and Administrator removed the food from the refrigerator.</p>	D 105		

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D 105	<p>Continued From page 15</p> <p>Interview with the Administrator on 06/07/16 at 3:25 p.m. revealed:</p> <ul style="list-style-type: none"> -She didn't understand why the temperature was not right with the refrigerator in the kitchen. -She would call a repairman to come and look at the refrigerator to check it. -She would remove the food items in the refrigerator until the repairman came and checked it and keep a check on the frozen food in the refrigerator. -She knew the temperature inside of the refrigerator went up everytime the refrigerator was opened. -She thought the temperature was better since she turned down the thermostat. -She thought the temperature in the refrigerator was okay for the food storage. -No one had ever told her that she should be checking the temperature inside of the refrigerator. <p>Observation of the refrigerator in the kitchen on 06/08/16 at 8:58 a.m. revealed:</p> <ul style="list-style-type: none"> -The temperature inside of the refrigerator read 38 degrees Fahrenheit. -A container labeled "beef and gravy - 06/07/16", a 16 ounce jar of relish, and a 15 ounce box of raisins were inside the refrigerator. -The containers inside the refrigerator were cold to touch. -No odors were noted coming from the refrigerator. -The food inside of the freezer side of the refrigerator was still solidly frozen. <p>Observation of the refrigerator in the kitchen of the facility on 06/08/16 at 9:05 a.m. revealed:</p> <ul style="list-style-type: none"> -The temperature inside of the refrigerator read 52 degrees Fahrenheit. 	D 105		

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D 105	<p>Continued From page 16</p> <ul style="list-style-type: none"> -The containers were still cold to touch. -The food inside of the freezer side of the refrigerator was still solidly frozen. <p>Observation of a bulletin board inside of the kitchen of the facility on 06/08/16 at 9:05 a.m. revealed:</p> <ul style="list-style-type: none"> -A paper titled " Temperature Guide for Food Protection" was posted on the bulletin board in the kitchen. -The guide read "keep cold foods cold (below 45 degree Fahrenheit)". <p>Interview with the Administrator on 06/08/16 at 3:25 p.m. revealed:</p> <ul style="list-style-type: none"> -She had called the repairmen to come and check the refrigerator. -She did not understand why the refrigerator was not maintaining its temperature. -She thought the temperature was better since she turned down the thermostat. -She knew the temperature inside of the refrigerator went up every time the refrigerator was opened. -She would remove the food in refrigerator until the repairmen came and checked it. <p>Observation of the refrigerator in the kitchen of the facility on 06/09/16 at 2:15 p.m. revealed:</p> <ul style="list-style-type: none"> -No food was stored in the refrigerator. -Temperature in the refrigerator was 42 degrees Fahrenheit. -Shelves inside of the refrigerator were cold to touch. <p>Interview with the Administrator on 06/09/16 at 2:39 p.m. revealed:</p> <ul style="list-style-type: none"> -A repairman had been to the facility and checked the refrigerator. -The repairmen had adjusted the thermostat in 	D 105		

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D 105	Continued From page 17 the refrigerator and he would return to recheck the refrigerator temperature. -The temperature in the refrigerator had been about 40 degrees Fahrenheit since the thermostat had been reset. -No food would be stored in the refrigerator until the temperature was stable for food storage. The cook for the facility was unavailable for interview prior to the end of the survey.	D 105		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the facility's water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 5 of 5 fixtures. The findings are: Observation of the water temperature in the sink located in the handicapped bathroom on 6/7/16 at	D 113		

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D 113	<p>Continued From page 18</p> <p>3:59 p.m. revealed water temperature was 82 degrees F.</p> <p>Observation of the water temperatures in the handicapped bathroom on 6/7/16 revealed: -At 4:09 p.m., the water temperature in the sink was 118 degrees F. -At 4:12 p.m., the water temperature in the shower was 118 degrees F.</p> <p>Interview with the Administrator on 6/7/16 at 4:12 p.m. revealed someone came and checked her water temperatures in the beginning of 2015.</p> <p>Observation of the water temperature in the sink located in bathroom A, which was located across room 21 closest to the kitchen, on 6/7/16 at 4:02 p.m. revealed the temperature was 122 degrees F.</p> <p>Observation of the water temperatures in bathroom B, which was located next to bathroom A closest to the side exit door, on 6/7/16 revealed: -At 4:04 p.m., the water temperature in the sink was 126 degrees F. -At 4:05 p.m., the water temperature in the tub was 124 degrees F.</p> <p>Observation on 6/7/16 at 4:11 p.m. revealed the Administrator had placed hot water signs in bathroom A and B on the walls above the sinks, which read "Be aware cautious water temperature 120 degrees."</p> <p>Interview with the Administrator on 6/8/16 at 8:30 a.m. revealed the repairman/electrician will be at the facility on 6/9/16 to check the hot water heater.</p>	D 113		

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D 113	<p>Continued From page 19</p> <p>Observation of the water temperatures in the handicapped bathroom on 6/8/16 revealed: -At 8:39 a.m., the water temperature in the shower was 120 degrees F. -At 8:41 a.m., the water temperature in the sink was 120 degrees F.</p> <p>Observation on 6/8/16 at 8:41 a.m. revealed a resident was using bathroom A.</p> <p>Observation of the water temperatures in bathroom B on 6/8/16 revealed: -At 8:43 a.m., the water temperature in the sink was 124 degrees F. -At 8:44 a.m., the water temperature in the tub was 124 degrees F.</p> <p>Observation on 6/8/16 from 8:46 a.m. to 8:53 a.m. revealed: -The Administrator and the surveyor calibrated both thermometers. -The Administrator's thermometer read 8 degrees F. -The surveyor's thermometer read 16 degrees F.</p> <p>Observation of the water temperatures in the handicapped bathroom on 6/8/16 revealed: -At 8:57 a.m., the Administrator's thermometer read 108 degrees F at the sink. The surveyor's thermometer read 114 degrees F at the sink. -At 8:58 a.m., the Administrator's thermometer read 118 degrees F at the shower. The surveyor's thermometer read 126 degrees F at the shower.</p> <p>Observation of the water temperatures in bathroom A on 6/8/16 at 9:01 a.m. revealed the Administrator's thermometer read 108 degrees F at the sink. The surveyor's thermometer read 126 degrees F at the sink.</p>	D 113		

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D 113	<p>Continued From page 20</p> <p>Observation of Resident #3 on 6/8/16 at 9:06 a.m. revealed: -The resident was coming out of bathroom B. -No other staff assisted the resident out of the bathroom. -The resident did not have a walker.</p> <p>Review of Resident #3's current FL-2 dated 1/13/16 revealed: -The resident had diagnoses for hypertension, edema, arthritis, Parkinson's disease, and dementia. The resident had intermittently disoriented. The resident was ambulatory with a walker. The resident was incontinent of bladder and continent of bowel.</p> <p>Review of Resident #3's Care Plan dated 1/13/16 revealed the resident required supervision with toileting and limited assistance with bathing.</p> <p>Based on observation, interview and record review, Resident #3 could not be interviewed.</p> <p>Interview with the Co-Administrator on 6/8/16 at 9:30 a.m. revealed Resident #3 went to the bathroom without staff assistance.</p> <p>Observation on 6/9/16 at 12:42 p.m. revealed the Administrator assisted Resident #3 in the bathroom to wash his hands.</p> <p>Observation of the water temperatures in bathroom B on 6/8/16 revealed: -At 9:06 a.m., the Administrator's thermometer read 110 degrees F at the sink. The surveyor's thermometer read 126 degrees F at the sink. -At 9:09 a.m., the Administrator's thermometer read 108 degrees F at the tub. The surveyor's</p>	D 113		

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D 113	<p>Continued From page 21</p> <p>thermometer read 120 degrees F at the tub.</p> <p>Interview with the Administrator on 6/8/16 at 9:12 a.m. revealed the facility's last documentation of the hot water temperatures was August 2011.</p> <p>Interview with a resident on 6/8/16 at 12:43 p.m. revealed: -The resident used the handicapped bathroom. -The water in the sink and shower get very hot. -When the water got too hot, the resident turned the water down or mixed the water with cold water. -The Supervisor's knew the water was hot. -The resident had not seen anyone "in quite a while" to work on the water temperatures. -The resident last used the shower the night of 6/7/16. "The shower was real hot last night."</p> <p>Interview with a second resident on 6/9/16 at 12:55 p.m. revealed: -The resident used the handicapped bathroom. -The water does not often get too hot. -If the water was too hot, the resident turned down the hot water and mixed the hot water with cold water. -The resident never complained to staff about the water being too hot.</p> <p>Interview with a third resident on 06/07/16 at 4:00 p.m. revealed: -The hot water in the facility got too hot sometimes. -The hot water was really too hot on the morning of 06/06/16. -The hot water almost burned her hand when she used the hot water from the sink in the restroom. -She tried to remember to turn on the cold water first when she used the hot water to avoid getting burned. -She had not complained about the hot water</p>	D 113		

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D 113	<p>Continued From page 22</p> <p>being too hot to staff.</p> <p>Interview with a fourth resident on 06/08/16 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> -The hot water in the facility was sometimes too hot. -The hot water felt like it was the hottest first in the morning. -He had to be careful to adjust the hot water when he turned it on in the bathroom. -He sometimes had to snatch his hand back because the hot water comes out too hot when he first turned on the hot water faucet. -He had not complained about the hot water temperature to staff because he did not want to get anyone in trouble. <p>Interview with a Personal Care Aide on 06/08/16 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The hot water was sometimes a little warmer than it should be. -The hot water temperature was okay once she adjusted the cold water with it. -A repairman had come out to check the hot water temperature about a month ago. -She did not know if the thermostat on the hot water heater had been adjusted or if any repairs had been done to the hot water heater. -She had not reported the hot water temperature to the administration. -She did not know of any complaints from the residents about the hot water being too hot. -She was not aware of any residents who had been burned after they used the hot water in the facility. <p>Interview with a second Personal Care Aide on 06/08/16 at 4:40 p.m. revealed:</p> <ul style="list-style-type: none"> -She did not know any problems with the hot water being too hot in the facility. 	D 113		

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D 113	<p>Continued From page 23</p> <p>-She was not aware of any complaints from the residents about the hot water being too hot in the facility.</p> <p>-She did not have any concerns with safety of the staff or the residents using the hot water in the facility.</p> <p>Interview with the Co-Administrator on 06/09/16 at 11:40 a.m. revealed:</p> <p>-She was not aware of any complaints from residents or staff about the hot water being too hot in the facility.</p> <p>-No residents had been burned from the hot water in the facility.</p> <p>-She and the Administrator would have to get a repairmen to come to check the hot water at the facility.</p> <p>Interview with the Administrator on 6/9/16 at 12:28 p.m. revealed:</p> <p>-The Administrator and the Co-Administrator usually checked the water temperatures daily.</p> <p>-The Administrator and the Co-Administrator had not checked the water temperatures in a while, because "we have had a lot going on."</p> <p>-She called her repairman the morning of 6/9/16 and he said he would come to the facility on 6/10/16 and turn down the water temperatures.</p> <p>-She had not had any current problems with the water temperatures.</p> <p>-She had problems with the water temperature many years ago, but she could not remember the year.</p> <p>-No one complained about the water temperatures.</p> <p>-She had a new hot water installed in the facility on 3/21/14.</p> <p>_____</p> <p>The facility submitted a Plan of Protection dated 6/9/16, as follows:</p>	D 113		

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D 113	<p>Continued From page 24</p> <ul style="list-style-type: none"> -Immediately, the Administrator informed the residents the hot water temperature was hot. -The Administrator posted signs in the bathroom informing residents of the hot water temperatures. -The Administrator contacted a repairman to come and turn down the hot water temperatures. -Staff will assist residents with usage in the bathrooms using the water until the temperatures are within the normal range (between 100-116 degrees Fahrenheit). -The Administrator and Co-Administrator will start checking water temperature daily. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 24, 2016</p>	D 113		
D 137	<p>10A NCAC 13F .0407(a)(5) Other Staff Qualifications</p> <p>10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall:</p> <p>(5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 4 of 5 sampled staff (B, C, D, E) had no substantiated findings on the North Carolina Health Care Personnel Registry (NCHCPR) upon hire.</p> <p>The findings are:</p> <p>A. Review of Staff B's, Medication Aide</p>	D 137		

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D 137	<p>Continued From page 25</p> <p>(MA)/Personal Care Aide (PCA), personnel file revealed: -She was hired to work at the facility 4/2/14. -There was no documentation of the HCPR check in Staff B's personnel file.</p> <p>Review of the HCPR print out dated 6/9/16 revealed: -The Administrator had completed a HCPR check on Staff B. -Staff B was not listed on the HCPR and did not have substantiated findings.</p> <p>Interview with a resident on 6/8/16 at 12:43 p.m. and interview with another resident on 6/9/16 at 12:55 p.m. revealed the residents did not have a problem with the treatment of staff.</p> <p>Interview with the Administrator on 6/9/16 at 12:05 p.m. revealed: -She kept up with staff personnel files. -She checked staff qualifications every 10 months to 1 year. -She had not checked staff qualifications in the past 12 months. -Before staff was hired, she checked the HCPR to make sure staff was not listed on it. -She checked Staff B's HCPR in either the beginning or middle of 2015. -Staff B was not listed on the HCPR and she could not find the documentation.</p> <p>Staff B was not available for interview.</p> <p>B. Review of Staff C's, PCA, personnel file revealed: -There was no documentation in the file when she was hired to work at the facility. -There was no documentation of the HCPR check in Staff C's personnel file.</p>	D 137		

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D 137	<p>Continued From page 26</p> <p>Interview with Staff C on 6/8/16 at 6:12 p.m. revealed: -She was hired to work at the facility on 4/1/13 as a PCA. -She does not "recall" if there had been an HCPR check before she was hired.</p> <p>Review of the HCPR print out dated 6/9/16 revealed: -The Administrator had completed a HCPR check on Staff C. -Staff C was not listed on the HCPR and did not have substantiated findings.</p> <p>Interview with a resident on 6/8/16 at 12:43 p.m. and interview with another resident on 6/9/16 at 12:55 p.m. revealed the residents did not have a problem with the treatment of staff.</p> <p>Interview with the Administrator on 6/9/16 at 12:05 p.m. revealed: -She kept up with staff personnel files. -She checked staff qualifications every 10 months to 1 year. -She had not checked staff qualifications in the past 12 months. -Before staff was hired, she checked the HCPR to make sure staff was not listed on it. -She checked Staff C's HCPR in either the beginning or middle of 2015. -Staff C was not listed on the HCPR and she could not find the documentation.</p> <p>C. Review of Staff D's, MA/PCA, personnel file revealed: -There was no documentation in the file when she was hired to work at the facility. -There was no documentation of the HCPR check in Staff D's personnel file.</p>	D 137		

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D 137	<p>Continued From page 27</p> <p>-Staff D had been working at the facility at least since 9/4/13.</p> <p>Interview with the Administrator on 6/9/16 at 12:02 p.m. revealed she could not remember Staff D's hire date.</p> <p>Review of the HCPR print out dated 6/9/16 revealed: -The Administrator had completed a HCPR check on Staff D. -Staff D was not listed on the HCPR and did not have substantiated findings.</p> <p>Interview with a resident on 6/8/16 at 12:43 p.m. and interview with another resident on 6/9/16 at 12:55 p.m. revealed the residents did not have a problem with the treatment of staff.</p> <p>Interview with the Administrator on 6/9/16 at 12:05 p.m. revealed: -She kept up with staff personnel files. -She checked staff qualifications every 10 months to 1 year. -She had not checked staff qualifications in the past 12 months. -Before staff was hired, she checked the HCPR to make sure staff was not listed on it. -She checked Staff D's HCPR in either the beginning or middle of 2015. -Staff D was not listed on the HCPR and she could not find the documentation.</p> <p>Staff D was not available for interview.</p> <p>D. Review of Staff E's, Cook, personnel file revealed: -There was no documentation in the file when she was hired to work at the facility. -There was no documentation of the HCPR check</p>	D 137		

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D 137	<p>Continued From page 28</p> <p>in Staff E's personnel file.</p> <p>Interview with the Administrator on 6/9/16 at 12:02 p.m. revealed Staff E was hired to work as a Cook at the facility on 9/1/11.</p> <p>Review of the HCPR print out dated 6/9/16 revealed: -The Administrator had completed a HCPR check on Staff E. -Staff E was not listed on the HCPR and did not have substantiated findings.</p> <p>Interview with a resident on 6/8/16 at 12:43 p.m. and interview with another resident on 6/9/16 at 12:55 p.m. revealed the residents did not have a problem with the treatment of staff.</p> <p>Interview with the Administrator on 6/9/16 at 12:05 p.m. revealed: -She kept up with staff personnel files. -She checked staff qualifications every 10 months to 1 year. -She had not checked staff qualifications in the past 12 months. -Before staff was hired, she checked the HCPR to make sure staff was not listed on it. -She checked Staff E's HCPR in either the beginning or middle of 2015. -Staff E was not listed on the HCPR and she could not find the documentation.</p> <p>Staff E was not available for interview.</p>	D 137		
D 150	<p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>10A NCAC 13F .0501 Personal Care Training And Competency</p>	D 150		

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D 150	<p>Continued From page 29</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 interviews and record reviews, the facility failed to assure 3 of 3 staff, personal care aides (PCA's), received the 80 hours personal care training and competency.</p> <p>The findings are:</p> <p>A. Review of Staff A's, Medication Aide (MA)/PCA, personnel file revealed: -There was no documentation in the file when she was hired to work at the facility. -There was no documentation of the 80 hours of the personal care training and competency. -There was no documentation of completion of a nurse aide course.</p>	D 150		

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D 150	<p>Continued From page 30</p> <p>Interview with Staff A on 6/8/16 at 6:02 p.m. revealed: -She was hired to work at the facility as a PCA in 2007. -She had not completed the 80 hours personal care training and competency. -She had completed a Nurse Aide course 3/26/16, but she had not taken the test to become a Certified Nursing Assistant (CNA).</p> <p>Interview with the Administrator on 6/9/16 at 2:05 p.m. revealed all Staff A bathe, dressed groomed and assisted residents with transfers.</p> <p>Refer to interview with the Administrator on 6/9/16 at 12:05 p.m.</p> <p>B. Review of Staff B's, MA/PCA, personnel file revealed: -She was hired to work at the facility 4/2/14. -There was no documentation of the 80 hours personal care training and competency.</p> <p>Interview with the Administrator on 6/9/16 at 2:05 p.m. revealed all Staff B dressed groomed and assisted residents with transfers.</p> <p>Staff B was not available for interview.</p> <p>Refer to interview with the Administrator on 6/9/16 at 12:05 p.m.</p> <p>C. Review of Staff C's, PCA, personnel file revealed: -There was not documentation in the file when she was hired to work at the facility. -There was no documentation of the 80 hours of the personal care training and competency.</p> <p>Interview with Staff C on 6/8/16 at 6:12 p.m.</p>	D 150		

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D 150	<p>Continued From page 31</p> <p>revealed:</p> <ul style="list-style-type: none"> -She was hired to work at the facility on 4/1/13 as a PCA. -She was unsure if she had completed the 80 hours personal care training and competency. <p>Interview with the Administrator on 6/9/16 at 2:05 p.m. revealed all Staff C bathe, dressed groomed and assisted residents with transfers.</p> <p>Refer to interview with the Administrator on 6/9/16 at 12:05 p.m.</p> <p>_____</p> <p>Interview with the Administrator on 6/9/16 at 12:05 p.m. revealed:</p> <ul style="list-style-type: none"> -She kept up with staff personnel files. -She checked staff qualifications every 10 months to 1 year. -She had not checked staff qualifications in the past 12 months. -She was unaware the personal care training and competency was required. 	D 150		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care</p> <p>(c) The facility shall assure documentation of the following in the resident's record:</p> <p>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</p> <p>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p>	D 276		

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D 276	<p>Continued From page 32</p> <p>Based on observation, record review, and interview, the facility failed to assure physician ordered blood sugar checks were done for 2 of 2 sampled residents (#1, #2).</p> <p>The findings are:</p> <ol style="list-style-type: none"> Review of Resident #1's current FL-2 dated 02/26/16 revealed the resident's diagnoses included Schizo-Affective disorder, hypertension, diabetes type II with complications, obesity, and acid reflux. <p>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 06/25/14.</p> <p>Review of a physician's order dated for 03/16/16 revealed: -Resident #1 needed a glucometer to check her blood once daily. -Goal of fasting glucose was 120 and postprandial 2 hours after meals was 140 to 160.</p> <p>Staff was unable to located the March 2016 Medication Administration Record (MAR) for Resident #1.</p> <p>Review of Resident #1's March 2016 Facility Blood Sugar Record (BSR) revealed there was no documentation of a blood sugar on 03/30/16.</p> <p>Review of Resident #1's April 2016 MAR revealed: -Blood sugars were transcribed to be checked at 7:30 a.m. and 7:00 p.m. -Blood sugars were not documented on the MAR from 04/01/16 through 04/08/16, 4/14/16 through 04/20/16, and 04/30/16 at 7:30 a.m.</p>	D 276		

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D 276	<p>Continued From page 33</p> <p>-Blood sugars were not documented on the MAR from 04/01/16 through 04/08/16, 4/14/16 through 04/20/16, and 04/30/16 at 10:00 a.m.</p> <p>Review of Resident #1's April 2016 revealed blood sugars were not documented on 04/02/16, 04/05/16 through 04/10/16, 04/13/16 through 04/16/16, and 04/17/16 through 04/30/16.</p> <p>Review of Resident #1's May 2016 MAR revealed: -Blood sugars were transcribed to be checked at 7:30 a.m. and 10:00 a.m. -There were no blood sugars documented as performed for the month of May 2016.</p> <p>Review of Resident #1's May 2016 BSR revealed no blood sugars were documented 05/14/16 through 05/19/16 and 05/21/16 through 05/26/16.</p> <p>Review of Resident #1's June 2016 MAR revealed: -Blood sugars were transcribed to be checked at 7:30 a.m. and 10:00 a.m. -Blood sugars were initialized as done on 06/01/16 through 06/06/16 at 7:30 a.m. but no results were documented on the June 2016 MAR. -No blood sugars were documented as performed on 06/01/16 or 06/06/16 at 10:00 a.m. -No blood sugars were documented as performed on 06/07/16 or 06/08/16.</p> <p>Review of Resident #1's June 2016 BSR revealed no blood sugars were documented 06/01/16 through 06/02/16 and 06/05/16 through 06/06/16.</p> <p>Observation on 06/09/16 at 6:05 p.m. revealed: -A black pouch labeled with Resident #1's name. -A glucometer, was not labeled with a name, was inside the pouch.</p>	D 276		

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D 276	<p>Continued From page 34</p> <p>-The pouch was kept in the top drawer of the facility's medication cart.</p> <p>Review of Resident #1's March 2016 Glucometer Results revealed there were no blood sugars results for 03/24/16 and 03/30/16.</p> <p>Review of Resident #1's April 2016 Glucometer Results revealed there were no blood sugars documented for 04/02/16 through 04/03/16, 04/05/16 through 04/08/16, 04/14/16 through 04/16/16, 04/18/16 through 04/24/16, 04/26/16 through 04/27/16, and 04/30/16.</p> <p>Review of Resident #1's May 2016 Glucometer Results revealed there were no blood sugars documented on 05/10/16, 05/14/16 through 05/19/16, 05/21/16 through 05/25/16. and 05/28/16.</p> <p>No Glucometer Results were available for Resident #1 for June 2016.</p> <p>Review of Progress Notes for Resident #1 revealed:</p> <p>-Resident #1 did not have any blood sugar test strips 05/14/16 through 05/19/16.</p> <p>-Blood strips from a staff member were used to check Resident #1's blood sugar 05/26/16 through 05/31/16.</p> <p>-The facility continued to contact the medical supply company to contact the physician for the order for blood sugar testing strips.</p> <p>-Resident #1 did not have any blood sugar test strips 06/01/16 through 06/02/16.</p> <p>-Resident #1's blood sugar was checked on 06/03/16 and 06/04/16 with blood sugar test strips from another resident.</p> <p>-The Administrator advised the Medication Aides not to share blood sugar test strips amongst the</p>	D 276		

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D 276	<p>Continued From page 35</p> <p>residents.</p> <p>-The Administrator called the medical supply company to track the signed order for the blood sugar testing strips for Resident #1.</p> <p>Interview with the Co-Administrator on 06/07/16 at 10:50 a.m. revealed:</p> <p>-Resident #1 had a physician's order to have her blood sugar checked twice daily</p> <p>-Sometimes, the blood sugar for Resident #1 was not checked because the resident did not have strips for her glucometer.</p> <p>-Resident #1's insurance would pay for her blood sugar strips if the strips were ordered through a medical supply company.</p> <p>-The facility had sent the request for the physician to sign the order for blood strips to be ordered through the medical supply company in May 2016 but the physician had not signed the paperwork yet.</p> <p>-She believed the last time the blood sugar of Resident #1 was checked was in May 2016.</p> <p>-The physician for Resident #1 was aware that sometimes blood sugars are not checked because the resident didn't have blood sugar testing strips.</p> <p>-The facility tried to monitor what Resident #1 ate so her blood sugar would not be elevated.</p> <p>Interview with Resident #1 on 06/07/16 at 4:00 p.m. revealed:</p> <p>-She knew she was diabetic.</p> <p>-The staff checked her blood sugar about 4 times a day.</p> <p>-She wasn't aware of any problems with getting her blood sugar testing strips for her glucometer.</p> <p>Interview with the Nurse for the Physician for Resident #1 on 06/08/16 at 2:10 p.m. revealed:</p> <p>-The physician's office was not aware until</p>	D 276		

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D 276	<p>Continued From page 36</p> <p>05/16/16 the blood sugars were not being checked daily for Resident #1 because Resident #1 did not have any blood sugar testing strips sometimes.</p> <p>-The physician's office had signed the order on 05/23/16 and faxed the order for the blood sugar testing strips to the facility and the medical supply company.</p> <p>-The physician's office expected the blood sugars of Resident #1 to be checked daily and to be notified if the facility is unable to check the blood sugar.</p> <p>Interview with a Medication Aide on 06/08/16 at 4:40 p.m. revealed:</p> <p>-She thought Resident #1 was supposed to have her blood sugar twice a day.</p> <p>-Resident #1 had the order for blood sugar checks for about 2 months.</p> <p>-Resident #1 had not being able to get her blood sugar check as ordered because she didn't have blood sugar testing strips.</p> <p>-She sometimes gave Resident #1 blood sugar testing strips from her supply since she and Resident #1 had the same glucometer.</p> <p>-She documented the blood sugar results on the MAR for Resident #1 and on the facility's blood sugar logs.</p> <p>-She had not called the doctor about Resident #1 needing an order for blood sugar test strips.</p> <p>Interview the Administrator on 06/09/16 at 2:30 p.m. revealed:</p> <p>-It was expected for staff to check the blood sugar of Resident #1 once daily.</p> <p>-The Medication Aides were supposed to document the blood sugar results on the facility's blood sugar record and on the MAR for the Resident #1.</p> <p>-There had been a problem with Resident #1</p>	D 276		

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NAME OF PROVIDER OR SUPPLIER TWIN OAKS AND TWINS ADULT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE BLDG # 817 HIGHWAY 258 NORTH COMO, NC 27818
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D 276	<p>Continued From page 37</p> <p>getting her blood sugar testing strips but medical supply company had the order to send them now. -The blood sugar strips were being sent by mail for Resident #1. -The facility had contacted the physician for Resident #1's missed blood sugar checks but there was no documentation of contact with physician in the records for Resident #1.</p> <p>Interview the Administrator on 06/09/16 at 6:10 p.m. revealed: -She was not aware there was problem with Resident #1 blood sugars not being documented on the MAR and the facility's blood sugar record. -She did not understand why the results sometimes differed from between the MAR blood sugars, the facility's blood sugar records, and the glucometer for Resident #1. -She expected the Medication Aides to document the blood sugar results from the glucometer for Resident #1 on the MAR and the facility's blood sugar record form. -She did not know why the blood sugars results were not documented on the June 2016 MAR even though the Medication Aide documented that blood sugars were checked for Resident #1 from 06/01/16 through 06/09/16. -She did not understand why there were no results found in the glucometer for Resident #1 for June 2016. -She would have to call the Medication Aide to find out what happened.</p> <p>The Medication Aide who took the a.m. blood sugar on 06/09/16 could not be reached by the end of the survey.</p> <p>2. Review of Resident #2's current FL-2 dated 9/1/15 revealed the resident had diagnoses of schizophrenia disorder and mild retardation.</p>	D 276		

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D 276	<p>Continued From page 38</p> <p>Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 10/16/14.</p> <p>Review of Resident #2's record included a physician's order dated 5/17/16 to check the resident's blood sugars twice daily.</p> <p>Review of Resident #2's progress notes dated 5/16/16 (no time) revealed: -The primary care physician's office was contacted, because the resident had frequent urination and excessive thirst.</p> <p>Review of Resident #2's blood sugar log revealed the log was dated from 5/17/16 to 6/5/16.</p> <p>Review of the blood sugars from 5/17/16 to 5/31/16 revealed: -Nine out of twenty nine opportunities there was no documentation of blood sugars on the blood sugars logs. -From 5/29/16 to 5/31/16, there was no documentation of FSBS in the 7:30 a.m. column and no staff initials in the staff initials column . -On 5/29/16, there was no documentation of FSBS and no initials in the staff initials column in the 5:00 p.m. column. -On 5/22/16, 5/23/16 and 5/24/16, no strips was written in the 7:30 a.m. column. There was no documentation of FSBS. There were no staff initials in the staff initial column -On 5/22/16 and 5/23/16, "p.m." was written in the 5:00 p.m. column. There was no documentation of FSBS and no staff initials in the staff initials column.</p> <p>Review of Resident #2's May 2016 MAR revealed:</p>	D 276		

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D 276	<p>Continued From page 39</p> <p>-Blood sugars twice a day in the a.m. and p.m. were transcribed on the MAR.</p> <p>-The times to take the blood sugars were not on the MAR.</p> <p>-From 5/21-5/25/16 and on 5/29/16, there was no documentation of the a.m. and p.m. FSBS.</p> <p>Review of Resident #2's blood sugars from 6/1/16 to 6/8/16 revealed:</p> <p>-Six out of fifteen opportunities there was no documentation of the blood sugars on the log.</p> <p>-On 6/5/16 at 5:00 p.m., there was no documentation of FSBS. Staff initialed in the initials column.</p> <p>-There was no documentation of FSBS from 6/6-6/8/16.</p> <p>Review of Resident #2's June 2016 MAR revealed:</p> <p>-Blood sugars twice a day in the a.m. and p.m. were transcribed on the MAR.</p> <p>-The times to take the blood sugars were not on the MAR.</p> <p>-There was no documentation of the FSBS from 6/1-6/8/16.</p> <p>Interview with the Administrator on 6/8/16 at 11:50 a.m. revealed:</p> <p>-When Resident #2 was diagnosed as a diabetic on 5/16/16, he received blood glucose monitoring supplies, which included the blood glucose strips. Ten strips came with the supplies.</p> <p>-If the areas are blank on the MAR or the blood sugar log, staff may not have taken Resident #2's blood sugars.</p> <p>-From 5/22-5/24/16, the blood sugars were not taken, because staff told her they could not find the blood glucose strips.</p> <p>-Staff did not tell her they could not find the strips until after the blood sugar had not been taken.</p>	D 276		

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D 276	<p>Continued From page 40</p> <p>-If a resident did not have strips, the facility bought strips.</p> <p>Interview with Resident #2 on 6/8/16 at 12:43 p.m. revealed: -Staff did not take the residents blood sugars daily. -"They take it every once in a while."</p> <p>Interview with a Medication Aide (MA) on 6/8/16 at 5:45 p.m. revealed: -She worked at the facility as a MA and PCA. -When she took the resident's blood sugars, she wrote the results on the back of the blood sugar log or she left the Administrator a note of the blood sugar results. -"I probably was trying to help other residents and did not write the blood sugars down."</p> <p>Telephone interview with Resident #2's primary care physician's nurse on 6/8/16 at 1:45 p.m. revealed: -The resident had an order dated 5/17/16 to take blood sugars twice daily. -The physician was not aware resident #2's blood sugars had not been taken on someday's May 2016, because the resident did not have strips. -The facility requested an order for blood glucose monitoring strips on 5/23/16.</p> <p>Interview with the Administrator on 6/9/16 at 6:11 p.m. revealed: -She did not know why the results to Resident #2 's blood sugars were not on the log or MAR. -She expected the MAs to document the blood sugar on the MAR and the facility's blood sugar record form. -She would have to call one of the MAs, who took Resident #2's blood sugars, to see why the blood sugars were not documented on the MARs.</p>	D 276		

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D 276	<p>Continued From page 41</p> <p>Observation of Resident #2's blood glucose monitoring strips label on 6/9/16 at 6:11 p.m. revealed the label was dated 5/17/16 and revealed there were 50 test strips. Use one strip to test blood sugars for poor diabetes control. There were four refills.</p> <p>A second MA, who took #2's blood sugars, could not be reached by the end of the survey.</p> <p>_____</p> <p>The facility submitted a Plan of Protection dated 6/17/16, as follows:</p> <ul style="list-style-type: none"> -Immediately, the Administrators checked the residents glucometers and Medication Administration Records (MARs) for accuracy and checked the residents glucose monitoring strips. -The Administrators will check the blood sugar log and the glucometer readings with staff daily. -The Administrators will make sure staff are following physician orders when checking fingerstick blood sugars (FSBS) daily. -The Administrators will check to make sure the residents have blood glucose strips and contact the resident's physician if the resident does not have blood glucose strips or has missed FSBS and will document in the resident's record. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 24, 2016</p>	D 276		
D 282	<p>10A NCAC 13F .0904(a)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes:</p> <p>(1) The kitchen, dining and food storage areas</p>	D 282		

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D 282	<p>Continued From page 42</p> <p>shall be clean, orderly and protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the refrigerators, stove, pantries, freezer, the doors, floors and walls in the kitchen and dining areas were cleaned, in good repair and free of contamination.</p> <p>The findings are:</p> <p>Observation of the dining room on 06/07/2016 at 10:55 a.m. revealed: -Two of the four walls had several black scuff marks. -Four of the four baseboards had several black marks and brown dust.</p> <p>Observation of the kitchen on 06/07/16 at 11:30 a.m. revealed: -Four of the four baseboards had black marks and brown dust. -Four of the four walls had scattered brown stains. -Four of four floor corners had brown stains and brown dust build-up. -The right and left exterior sides of the refrigerator had brown stains. -The exterior gasket of the refrigerator door had brown spots. -The interior gasket of the refrigerator door had several brown spots. -The interior of the freezer of the refrigerator had several small brown stains. -The vent cover at the bottom of the refrigerator had brown dust across the top edge. -The hood over the stove had greasy brown build-up. -The exterior of the stove door had white spots</p>	D 282		

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D 282	<p>Continued From page 43</p> <p>with a greasy residue.</p> <ul style="list-style-type: none"> -The four drip pans of the stove had black and brown greasy build-up. -The five control knobs on the front of the stove had crusted brown residue build-up. -The stove griddle was discolored with brown and black stains. -A live bug was on top of the stove griddle. -The interior of the stove had burned black and brown stains with a white residue. -The cabinet to the right side of the stove had several scuff marks. -The top of the wooden table in the kitchen had several brown scuff marks. -The front panels of the four cabinets over the sinks had dark brown sludge residue build up with several scuffs areas to all of the cabinets. -The underside of the handwashing sink had brown dusty residue. -Both cabinets adjacent to the handwashing sink had several scuffed areas. -The can opener located next to the microwave had dark brown buildup. <p>Observation of the pantry next to the kitchen on 06/07/16 at 11:35 a.m. revealed:</p> <ul style="list-style-type: none"> -Two of three walls had several black scuff marks. -Two of three baseboards had brown dust. -Ten of ten shelves had brown residue build-up and dark brown stains. <p>Observation of the outside pantry adjacent to the back porch on 06/07/16 at 11:40 a.m. revealed:</p> <ul style="list-style-type: none"> -Four of four walls had several black scuff marks. - Four of four baseboards had brown dust. -Numerous black and brown dead insects were on the floor of the pantry. -A large brown stain was on the left side of the ceiling. 	D 282		

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D 282	<p>Continued From page 44</p> <ul style="list-style-type: none"> -There was a black stain to the left corner of the ceiling. -Large dusty, brown cobwebs were in two of four corners of the ceiling in the pantry. -Eighteen of eighteen racks had black smudges and black marks covered with brown dust. <p>Interview with the Cook on 06/07/16 at 11:20 a.m. revealed:</p> <ul style="list-style-type: none"> -She cleans in the kitchen every day she works. -The floor of the kitchen is swept and mopped every day. -She cleaned the walls in the kitchen about once a month. -She cleaned the baseboards in the kitchen when she cleaned the walls. -She cleaned the inside and the outside of the refrigerator about once a week. -She cleaned the refrigerator last week. -The facility contracted with an outside company to clean the hood over the stove. -She cleaned the outside of the stove and griddle every day. -She cleaned the oven about once a month. -She last cleaned the oven about 2 weeks ago. -She had put baking soda in the bottom of the oven the week of 05/23/16 to soak up the greasy and that is why there was white residue in the bottom of the oven. -The facility had an exterminator company to come out once a month to spray for bugs and it was about time now for the facility to be sprayed again. -The facility had bug spray outside in the pantry to kill bugs in between the exterminator company spraying. -She was not sure the last time she had cleaned the exteriors of the cabinets but all of the cabinets were old and worn. -She did not clean the can opener next to the 	D 282		

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D 282	<p>Continued From page 45</p> <p>microwave.</p> <p>-She cleaned the pantry next to the kitchen and the outside pantry about once a month.</p> <p>-Both pantries were cleaned in May 2016.</p> <p>-She cleaned all the racks and swept and mopped the floors in both pantries in May 2016.</p> <p>-The facility did not have a cleaning schedule for the kitchen or the pantries.</p> <p>Interview with the Administrator on 06/07/16 at 1:30 p.m. revealed:</p> <p>-It was the expectation that the cook would keep the kitchen and the inside pantry clean.</p> <p>-She and the Co-Administrator did not check behind the cook for the cleanliness of the kitchen.</p> <p>-She was not sure the last time the refrigerator or stove had been cleaned.</p> <p>-She thought the cook cleaned the inside pantry about once a month but she was not sure the last time it was done.</p> <p>-The responsibility of cleaning the outside pantry was for the cook, Co-Administrator, and the Administrator.</p> <p>-They all worked together to keep it clean and organized.</p> <p>-The last time the outside pantry was cleaned was about 3 months ago.</p> <p>-She knew the outside pantry needed to be cleaned but they all had been very busy taking care of the inside of the facility.</p> <p>-They would try to clean the outside pantry as soon as possible.</p>	D 282		
D 283	<p>10A NCAC 13F .0904(a)(2) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes:</p>	D 283		

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D 283	<p>Continued From page 46</p> <p>(2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure foods were stored in a manner to prevent contamination related to fluctuating refrigerator temperatures, food storage in the outside pantry, the outside pantry temperature and expired food in the outside pantry.</p> <p>The findings are:</p> <p>Observation of the outside pantry adjacent to the back porch on 06/07/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> -The temperature inside of the outside pantry was 90 degrees Fahrenheit. -This pantry was used for dry food storage, cleaning products, pots, pans, toilet seats, medical supplies, and other dry items. -An opened bag of sweet onions was on the shelf next to a disinfectant solution. -A can of shaving cream was stored on a shelf next to 2 boxes of macaroni. -Two gallons bleach was stored on the floor next to a container of rice. -Seven white large food storage bins had brown and yellow stains on their sides and lids. -An unopened box of swedish meatball mix with an expiration date of 11/17/15 was on the back shelf. -On the back shelf were five boxes of unopened pumpkin spice Jello that had expiration dates of 08/21/14. -Two unopened boxes of water crackers with the expiration dates of 10/14/2012 were on the back shelf. -An unopened bottle of pink grapefruit had turned dark brown and had the expiration date of 	D 283		

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D 283	<p>Continued From page 47</p> <p>06/14/13 was on the back shelf.</p> <ul style="list-style-type: none"> -Other dry goods such as black bean, peanut butter, corn, pickles, mustard, ketchup, rice, confectioner sugar, macaroni, tuna, and grape concentrate were stored in the outside pantry. -All of the food containers were hot to touch. <p>Observation of the freezer located in the outside pantry on 06/07/16 at 1:00 p.m. revealed:</p> <ul style="list-style-type: none"> -The first shelf inside of the freezer contained raw frozen chicken breasts, various sandwich meats, raw frozen hamburger, and cornbread dressing. -The second shelf of the freezer contained frozen raw hamburger, frozen raw chicken, frozen deli ham meat, and butter. -The third shelf of the freezer contained frozen raw chicken, frozen raw ham hocks, frozen sandwich meat, and frozen apple pies. -The pull-out shelf of the freezer contained egg salad, various snack packs, frozen hotdogs, and frozen sandwich meats. -The fourth shelf of the freezer contained butter, macaroni and cheese dinner, crab salad, and frozen deli sandwich meat. -The fifth shelf of the freezer contained pizza dough, frozen liverwurst, crab salad, and frozen pork sausage. -Several of the meat packed in the freezer were labeled "Manager's Special" for quick sale due to expiration dates. <p>Interview with the Administrator on 06/07/016 at 3:20 p.m. revealed:</p> <ul style="list-style-type: none"> -It was the responsibility of her, the Co-Administrator, and the Cook to keep the outside pantry clean and to make sure the foods expired foods was not served to the residents. -Food items were supposed to be stored on the right side of the outside pantry and non-food items on the left side of the outside pantry. 	D 283		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 283	Continued From page 48 -The outside pantry had not been cleaned in about 3 months because the staff had gotten too busy with keeping the inside of the facility clean. -She was not sure of the last time that she had checked the foods in the freezer or the outside pantry for their expiration dates. -She would make sure to remove the expired foods from the outside pantry. -She usually checked the food items by sight and if the food looked bad she threw it away. -She did most of the shopping for food and supplies needed for the facility. -She brought a lot of food on the quick sale for Manager Specials because it was cheaper. -She thought once the food was frozen that the expiration dates did not matter anymore. -She would be more mindful buying foods and their expiration dates.	D 283		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to assure any substitutions made in the menu to be of equal nutritional value, appropriate for the regular diet and therapeutic diets (No Added Salt [NAS], 1800 Calorie American Diabetes Association (ADA) Diet, No Concentrated Sweets [NCS], Low Cholesterol) and documented to indicate the foods actually served to the residents.	D 292		

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D 292	<p>Continued From page 49</p> <p>The findings are:</p> <p>Observation of the kitchen on 06/07/2016 at 10:55 a.m. revealed:</p> <ul style="list-style-type: none"> -There was no menus posted for 06/07/16 in the kitchen or the dining room. -There was no diet list or food substitution list posted in the kitchen or the dining room. -There was no food substitution log for the kitchen. -Therapeutic menus were posted in the dining room for a Regular diet, a Mechanical Soft diet, a No Added Salt diet, and 1800 Calorie Controlled Diabetic diet. <p>Interview with the Co-Administrator on 06/07/16 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -The facility did not have a posted diet list. -All therapeutic diet orders were in the residents' chart. -Therapeutic menus were posted in the dining room. -She told the cook what therapeutic diet was ordered for each resident. -She followed the therapeutic menus that were posted in the dining room to tell the cook what needed to be prepared. -The facility did not have a substitution log. <p>Interview with the Cook on 06/07/16 at 11:20 a.m. revealed:</p> <ul style="list-style-type: none"> -She had been working in the kitchen for 7 years. -The Co-Administrator and Administrator told her what therapeutic diets were ordered for each resident. -She was not aware if there was a substitution log for the facility. <p>Review of the Week 4 Lunch "Weekly Menu Fall</p>	D 292		

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D 292	<p>Continued From page 50</p> <p>Cycle" Day 2 posted in the dining room included sloppy joe sandwich, tater tots, carrot/raisin salad, sherbet, milk, coffee, tea for Regular, Mechanical Soft, No Concentrated Sweets and 1800 Calorie Controlled Diabetic diets.</p> <p>Review of Week 4 lunch "Weekly Menu Spring Cycle" Day 2 NAS diet posted in the dining room revealed the residents were to receive broiled pork cutlets, tater tots, buttered corn, coleslaw, 1 slice of wheat bread, margarine, orange sherbet, milk, with coffee, tea, or decaffeinated coffee.</p> <p>There as no Low Cholesterol Diet menu available.</p> <p>Observation on 06/07/2016 at 12:05 p.m. revealed the lunch meal was substituted and there was no substitution list available.</p> <p>Observation of the lunch meal on 06/07/2016 at 12:05 p.m. revealed:</p> <ul style="list-style-type: none"> -All residents were served water. -One resident was served diet cola. -Five residents were served a bologna sandwich with mayonnaise, one pickle slice, and a piece of 3 x 3 chocolate cake with white icing. -One resident was served 2 bologna sandwiches with mayonnaise, one pickle slice, and a piece of 3 x 3 chocolate cake with white icing. -One resident was served a bologna sandwich with mayonnaise and two pickle slices. -One resident was served one peanut sandwich. -There was no milk, tea, coffee served. -The lunch meal was substituted different from the posted menu but no substitution list was made. <p>Interview with the Cook on 06/07/2016 at 12:35 p.m. revealed:</p>	D 292		

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D 292	<p>Continued From page 51</p> <ul style="list-style-type: none"> -She prepared lunch on 06/07/16 as she had been told to do by the Co-Administrator. -There was no menu posted in the kitchen. -She did not look at the therapeutic menus posted in the dining room. -The substitutions for lunch today were not documented. -There was no substitution log for the facility. -Water was the only beverage they served with meals for the residents. <p>Review of the Week 4 breakfast "Weekly Menu Fall Cycle" posted in the dining room included poached egg, hash browns, English muffin with margarine, jelly, grape juice, milk, coffee or tea Regular, Mechanical Soft, No Added Salt, and 1800 Calorie Controlled Diabetic diets.</p> <p>Observation on 06/08/2016 at 9:30 a.m. revealed the breakfast meal was substituted and there was no substitution list available.</p> <p>Observation of a breakfast meal for Resident #3 on 06/08/2016 at 9:30 a.m. revealed the resident was served ½ grape jelly sandwich, one boiled egg, corn flakes with milk, water, grape juice, and milk.</p> <p>Interview with the Co-Administrator on 06/08/16 at 9:35 a.m. revealed:</p> <ul style="list-style-type: none"> -She prepared breakfast for Resident #3 on 06/08/16 since the cook was not working. -She changed the menu for Resident #3 because he didn't have any teeth and he needed soft foods. -She did not document the substitution for Resident #3's breakfast on 06/08/16. -The facility did not have a substitution log. <p>Review of the Week 4 lunch "Weekly Menu Fall</p>	D 292		

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D 292	<p>Continued From page 52</p> <p>Cycle" posted in the dining room included bologna & cheese sandwich with mayonnaise and mustard, raisins, chocolate pudding, and beverage.</p> <p>Observation on 06/08/2016 at 12:30 p.m. revealed the lunch meal was substituted and there was no substitution list available.</p> <p>Observation of a lunch meal for Resident #3 on 06/08/2016 at 12:30 p.m. revealed the resident was served chicken salad, baked apples, bread, milk, water, and tea.</p> <p>Review of the "Weekly Menu Spring Cycle - Week 4" No Added Salt diet dinner menu revealed the residents were to receive 3/4 cup creamed chicken with 1 biscuit, 1/2 cup buttered sliced carrots, 1/2 cup strawberries, 1/2 cup lemon carrot jello salad, 1/2 cup milk, tea, and decaffeinated coffee.</p> <p>Review of the "Weekly Menu Spring Cycle - Week 1" 1800 calorie ADA diet dinner menu revealed the residents were to receive 3/4 cup creamed chicken with 1 biscuit, 1/2 cup buttered sliced carrots, 1/2 cup strawberries, 1/2 cup lemon carrot jello salad, 1/2 cup milk, tea, and decaffeinated coffee.</p> <p>Observation on 06/08/2016 at 5:00 p.m. revealed the dinner meal was substituted and there was no substitution list available.</p> <p>Observation of Resident #1 during the dinner meal on 06/08/16 at 5:00 p.m. revealed: -The resident was eating the meal in the dining room. -The resident was served 1 baked chicken thigh, 1 cup green peas, 2-ounce piece of cornbread, 1</p>	D 292		

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D 292	<p>Continued From page 53</p> <p>slice of blueberry pie (1/6 of 8-inch pie), 12 ounces of sweet tea, and 12 ounces of water.</p> <p>Observation on 06/08/16 at 5:20 p.m. revealed Resident #1 had eaten all of the meal, had drank all of the sweet tea, but did not drink any of the water.</p> <p>Interview with the Administrator on 06/09/16 at 2:30 p.m. revealed: -The Co-Administrator usually worked with the Cook in preparing the residents' meals. -The meals were supposed to be prepared according to the menu cycle posted in the dining room. -The menu for Resident # 3 had changed today because he needed soft foods since he didn't have any teeth. -She was not aware that substitution lists or a substitution were needed in when the meals were prepared in the facility. -She would have to contact their Registered Dietitian to get a substitution list. -The facility would get a food substitution list from their Dietitian and start keeping a food substitution log.</p>	D 292		
D 296	<p>10A NCAC 13F .0904(c)(7) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record</p>	D 296		

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D 296	<p>Continued From page 54</p> <p>review, the facility failed to assure matching therapeutic menus for food service guidance for 4 of 4 sampled residents with physician orders for Low Salt/Low Cholesterol/Low American Diabetic Association (ADA) [#1], 1800 ADA/Low Concentrated Sweets (NCS) [#2], Soft, No Added Salt (NAS) [#3], and Low Salt diet (#4).</p> <p>The findings are:</p> <ol style="list-style-type: none"> Review of Resident #2's current FL-2 dated 9/1/15 revealed: <ul style="list-style-type: none"> -The resident had diagnoses of schizophrenia disorder and mild retardation. -There was a diet order for the Regular diet. <p>Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 10/16/14.</p> <p>Record review revealed Resident #2 had a subsequent diet order dated 5/17/16 which included the 1800 Calorie American Diabetes Association (ADA) Diet, Low Concentrated Sweets diet.</p> <p>Review of the diet list (not dated) received on 6/7/16 revealed Resident #2's diet included a "1800 Calorie ADA/Low Concentrated Sweets" diet.</p> <p>Review of the diet menus received on 06/07/16 revealed: <ul style="list-style-type: none"> -There was no menu for Low Concentrated Sweets diet. -The 1800 Calorie ADA lunch menu was 3 ounces (oz) sausage, 1/2 cup hash brown potatoes, 1/4 cup butter peas, 1/2 cup pineapple chunks, 1 slice wheat bread, 1 teaspoon (tsp.) margarine, 1/2 cup milk, coffee and/or tea. </p>	D 296		

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D 296	<p>Continued From page 55</p> <p>Observation of the lunch meal on 06/07/16 at 12:20 p.m. revealed Resident #2 was served a bologna sandwich with 2 slices of bologna and mayonnaise, 2 pickle spears, and 12 ounces of water.</p> <p>Interview with Resident #2 at 12:43 p.m. revealed: -He was on a low fat diabetic diet. -He received fried foods with the meals. -He drank sodas "once in a while." -Sometimes he received juice and milk. -He did not have a problem with the diet.</p> <p>Interview with Resident #2's primary care physician's nurse on 6/8/16 at 1:45 p.m. revealed: -The resident was seen by the primary care physician on 5/16/16. -The resident had an order for a diabetic diet. -May 2016, the resident had a diagnosis of Type II Diabetes Mellitus. -There was an order dated 5/16/16 for the resident to avoid high carbohydrate foods, sweets, breads, juices. The resident may have diet drinks and water. -The facility should follow the diet order based on the resident's FL-2. -The resident have not had any problems from the diet.</p> <p>Interview with the Administrator on 06/08/15 at 5:30 p.m. revealed: -The Co-Administrator was doing the cooking on 06/08/16 since the regular cook was off. -It was expected for the therapeutic diet menus to be followed for each resident according to the physician's orders. -She was not aware there had to be a combination diet menu for every combination diet</p>	D 296		

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D 296	<p>Continued From page 56</p> <p>order.</p> <p>-She would have to contact the facility's dietitian to see if she could get the combination diet menu or clarify a diet order with Resident #2's physician.</p> <p>Interview with the Administrator on 6/9/16 at 3:25 p.m. revealed:</p> <p>-The facility followed the 1800 Calorie ADA diet for Resident #2's diet.</p> <p>-She was unsure if the facility had a Low Concentrated Sweets Menu.</p> <p>-The facility did not have a combined 1800 ADA, Low Concentrated Sweets diet menu.</p> <p>-The Administrator and Co-Administrator checked behind staff at each meal to make sure they were preparing the correct diet for the residents.</p> <p>-She thought the residents were receiving the correct diets.</p> <p>By the end of the survey, the Administrator could not provide a Low Concentrated Sweets menu.</p> <p>Refer to interview with the Co-Administrator on 06/07/16 at 11:00 a.m.</p> <p>Refer to interview with the Cook on 06/07/16 at 11:20 a.m.</p> <p>2. Review of Resident #4's current FL-2 dated 2/19/16 revealed:</p> <p>-The resident had diagnoses of Chronic Obstructive Pulmonary Disease (COPD), high blood pressure and hyperlipidemia.</p> <p>-There was a diet order for the low salt diet.</p> <p>Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 5/31/95.</p>	D 296		

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D 296	<p>Continued From page 57</p> <p>Review of the diet list (not dated) received on 6/7/16 revealed Resident #4 was on a low salt diet.</p> <p>Review of the diet menus received on 06/07/16 revealed there was no Low Salt diet menu.</p> <p>Review of "Weekly Menu Spring Cycle - Week 4" Day 2 lunch NAS diet menu revealed the residents were to receive broiled pork cutlets, 1/2 cup tater tots, 1/2 cup buttered corn, 1/2 cup coleslaw, 1 slice of wheat bread, margarine, 1/2 cup orange sherbet, 1/2 milk, with coffee, tea, or decaffeinated coffee.</p> <p>Observation of the lunch meal on 06/07/16 at 12:20 p.m. revealed Resident #4 was served a bologna sandwich with 2 slices of bologna and mayonnaise, 1 pickle spears, 3 x 3 square of chocolate cake, 12 ounces of water, and 12 ounces of a soda.</p> <p>Interview with Resident #4 on 06/07/16 at 3:40 p.m. revealed: -He did not know that he was on any special diet. -He usually ate whatever the staff gave him for his meals. -The food at the facility was okay. -He does not eat much but he gets enough food at the facility.</p> <p>Telephone interview with Resident #4's primary care physician's nurse on 6/8/16 at 1:45 p.m. revealed: -The resident did not have a diet order on file. -The primary care physician's expectation was for the facility to monitor the resident's sodium intake. -The facility should follow the diet order based on the resident's FL-2.</p>	D 296		

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D 296	<p>Continued From page 58</p> <p>Interview with the Administrator on 06/08/15 at 5:30 p.m. revealed: -The Co-Administrator was doing the cooking on 06/08/16 since the regular cook was off. -It was expected for the therapeutic diet menus to be followed for each resident according to the physician's orders. -She was not aware there had to be a combination diet menu for every combination diet order.</p> <p>Interview with the Administrator on 6/9/16 at 3:25 p.m. revealed: -Staff followed the No Added Salt (NAS) menu when preparing Resident #4's diet. -Resident #4 had been on the low salt diet for one year. -She would need to clarify the diet order with Resident #4's physician. -The Administrator and Co-Administrator checked behind staff at each meal to make sure they were preparing the correct diet for the residents. -She thought the resident was receiving the correct diets.</p> <p>Refer to interview with the Co-Administrator on 06/07/16 at 11:00 a.m.</p> <p>Refer to interview with the Cook on 06/07/16 at 11:20 a.m.</p> <p>3. Review of Resident #1's current FL-2 dated 02/26/16 revealed: -The resident's diagnoses included Schizo-Affective disorder, hypertension, diabetes type II with complications, obesity, and acid reflux. -An order for Low Salt/Low Cholesterol/Low ADA diet.</p>	D 296		

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D 296	<p>Continued From page 59</p> <p>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 06/25/14.</p> <p>Review of Resident #1's record revealed there was no subsequent diet orders.</p> <p>Observation of the dining room on 06/07/2016 at 10:55 a.m. revealed: -Therapeutic menus were posted in the dining room for a Regular diet, a Mechanical Soft diet, a No Added Salt diet, and 1800 Calorie Controlled Diabetic diet. -There was no Low Salt therapeutic menu posted. -There was no Low Cholesterol therapeutic menu posted. -There was no low ADA therapeutic menu posted.</p> <p>Review of the diet list revealed Resident #1 was on a Low Salt/Low Cholesterol/Low ADA diet.</p> <p>Review of the "Weekly Menu Spring Cycle - Week 4" No Added Salt diet dinner menu revealed the residents were to receive 3/4 cup creamed chicken with 1 biscuit, 1/2 cup buttered sliced carrots, 1/2 cup strawberries, 1/2 cup lemon carrot jello salad, 1/2 cup milk, tea, and decaffeinated coffee.</p> <p>Review of the "Weekly Menu Spring Cycle - Week 1" 1800 calorie ADA diet dinner menu revealed the residents were to receive 3/4 cup creamed chicken with 1 biscuit, 1/2 cup buttered sliced carrots, 1/2 cup strawberries, 1/2 cup lemon carrot jello salad, 1/2 cup milk, tea, and decaffeinated coffee.</p> <p>Observation of Resident #1 during the dinner meal on 06/08/16 at 5:00 p.m. revealed:</p>	D 296		

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D 296	<p>Continued From page 60</p> <p>-The resident was eating the meal in the dining room.</p> <p>-The resident was served 1 baked chicken thigh, 1 cup green peas, 2-ounce piece of cornbread, 1 slice of blueberry pie (1/6 of 8-inch pie), 12 ounces of sweet tea, and 12 ounces of water.</p> <p>Observation on 06/08/16 at 5:20 p.m. revealed Resident #1 had eaten all of the meal, had drank all of the sweet tea, but did not drink any of the water.</p> <p>Review of June 2016 Medication Administration Record, facility Blood Sugar Record, and Glucometer machine revealed there were no blood sugar reading were documented for Resident #1 on 06/08/16.</p> <p>Telephone interview with nurse of the physician for Resident #1 on 06/08/16 at 2:10 p.m. revealed: -The facility should provide the diet as ordered by the physician. -If more clarification of the diet was needed, the facility would need to consult a dietitian for better guidelines.</p> <p>Interview with Resident #1 on 06/08/16 at 5:15 p.m. revealed: -She ate whatever food was given to her at the facility. -She knew she was a diabetic and she was not supposed to eat sweets because they made her blood sugar go up. -She thought the blueberry pie and sweet tea were okay for her to each since the cook gave it to her for dinner. -She did not know what diet her doctor had ordered for her.</p>	D 296		

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D 296	<p>Continued From page 61</p> <p>Interview with the Co-Administrator on 06/08/15 at 5:25 p.m. revealed:</p> <ul style="list-style-type: none"> -She did the cooking and plating of the food for the dinner meal on 06/08/16. -She forgot about the diet order for Resident #1 and put cornbread and blueberry pie on her plate. -She had given Resident #1 tea sweetened with sugar with her dinner on 06/08/16. -She just forgot that Resident #1 was a diabetic. -She was not aware there had to be a combination diet menu for every combination diet order. <p>Interview with the Administrator on 06/08/15 at 5:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The Co-Administrator was doing the cooking on 06/08/16 since the regular cook was off. -It was expected for the therapeutic diet menus to be followed for each resident according to the physician's orders. -The facility did not have a Low Salt/Low Cholesterol/Low ADA diet menu. -The facility was using the No Concentrated Sweets/No Added Salt diet for Resident #1. -The facility avoided giving Resident #1 any fatty foods. -The facility did not have a No Concentrated Sweets/No Added Salt diet menu. -She was not aware there had to be a combination diet menu for every combination diet order. -She would have to contact the facility's dietitian to see if she could get the combination diet menu. <p>Refer to interview with the Co-Administrator on 06/07/16 at 11:00 a.m.</p> <p>Refer to interview with the Cook on 06/07/16 at 11:20 a.m.</p>	D 296		

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D 296	<p>Continued From page 62</p> <p>4. Review of Resident #3's current FL-2 dated 01/13/16 revealed: -The resident's diagnoses were hypertension, edema, arthritis, dementia, and Parkinson's disease. -The resident was intermittently disoriented. -A physician's order for a No Added Salt (NAS) diet.</p> <p>Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 07/08/12.</p> <p>Review of Resident #3's record revealed a current physician's order dated 04/27/16 which included a Soft - No Added Salt diet.</p> <p>Observation of the dining room on 06/07/2016 at 10:55 a.m. revealed therapeutic menus were posted in the dining room for a Regular diet, a Mechanical Soft diet, a No Added Salt diet, and 1800 Calorie Controlled Diabetic diet.</p> <p>Review of the diet list revealed Resident #3 was on a NAS soft diet.</p> <p>Review of "Weekly Menu Spring Cycle - Week 4" Day 2 lunch NAS diet menu revealed the residents were to receive broiled pork cutlets, 1/2 cup tater tots, 1/2 cup buttered corn, 1/2 cup coleslaw, 1 slice of wheat bread, margarine, 1/2 cup orange sherbet, 1/2 milk, with coffee, tea, or decaffeinated coffee.</p> <p>Observation of Resident #3 during the lunch meal on 06/07/16 at 12:10 p.m. revealed: -The resident was eating the meal in the dining room. -The resident was served 1 peanut butter sandwich using 2 slices of wheat bread.</p>	D 296		

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D 296	<p>Continued From page 63</p> <p>-The resident brought his own drink container that contained 20 ounces of water.</p> <p>Observation on 06/07/16 at 1:20 p.m. revealed: -Resident #3 had eaten 50 percent of the meal and 3 ounces of water. -The staff had given ½ cup of macaroni and cheese to Resident #3 but Resident #3 did not eat any of it.</p> <p>Interview with the Co-Administrator on 06/07/16 at 11:00 a.m. revealed: -Resident #3 was on a Soft NAS diet because he didn't have any teeth. -The facility did not have a Soft Diet but they gave Resident #3 soft foods to eat. -She did not give Resident #3 canned soups and avoided serving him processed foods. -No salt was added to the food when it was cooked at the facility. -She had instructed the cook to rinse the canned vegetables.</p> <p>Resident #3 was not able to be interviewed due to his cognitive state.</p> <p>Interview with the Cook on 06/07/16 at 1:22 p.m. revealed: -She fixed lunch for Resident #3 as she was directed by the Co-Administrator. -She didn't think Resident #3 could chew the bologna sandwich the other residents got. -She had been told by the Co-Administrator to give the macaroni and cheese to Resident #3 to go with his peanut butter sandwich.</p> <p>Interview with the Co-Administrator on 06/07/16 at 1:25 p.m. revealed: -Resident #2 was given the peanut butter sandwich with the macaroni and cheese because</p>	D 296		

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D 296	<p>Continued From page 64</p> <p>he couldn't chew the bologna sandwich that was prepared for the other residents. -Bologna was not allowed on the NAS diet. -Macaroni and Cheese was allowed on the NAS diet.</p> <p>Interview with the Administrator on 06/09/16 at 3:50 p.m. revealed: -It was expected for the therapeutic diet menus to be followed for each resident according to the physician's orders. -The facility made sure to follow the No Added Salt diet for Resident #3. -The facility sometimes had to substitute certain foods on the diet menu because Resident #3 needed a Soft diet. -She would have to contact the facility's dietician to see if she could get a diet menu for a Soft NAS diet.</p> <p>Refer to interview with the Co-Administrator on 06/07/16 at 11:00 a.m.</p> <p>Refer to interview with the Cook on 06/07/16 at 11:20 a.m.</p> <hr/> <p>Interview with the Co-Administrator on 06/07/2016 at 11:00 a.m. revealed: -The facility did not have a posted diet list. -All therapeutic diet orders were in the resident's chart. -Therapeutic menus were posted in the dining room. -She told the cook what therapeutic diet was ordered for each resident. -She followed the therapeutic menus that were posted in the dining room to tell the cook what needed to be prepared. -No salt was added to the food when it was cooked at the facility.</p>	D 296		

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D 296	<p>Continued From page 65</p> <ul style="list-style-type: none"> -She had instructed the cook to rinse the canned vegetables. -The facility monitored the concentrated sweets and carbohydrates for diabetic residents. <p>Interview with the Cook on 06/07/2016 at 11:20 a.m. revealed:</p> <ul style="list-style-type: none"> -She had been working in the kitchen for at least 7 years. -The Administrator and Co-Administrator told her what therapeutic diets wer ordered for each resident. -No resident diet sheets were posted in the kitchen. -She did not add any salt to her food when cooked. -She rinsed the canned vegetables prior to cooking them. -For diabetic residents, she gave them fresh fruit, sugar-free applesauce or sugar-free canned fruit. -She tried to avoid giving the diabetic residents concentrated sweets. 	D 296		
D 298	<p>10A NCAC 13F .0904(d)(2) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.</p> <p>This Rule is not met as evidenced by: Based on record review, observations, and interviews, the facility failed to offer snacks to all residents three times a day.</p>	D 298		

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D 298	<p>Continued From page 66</p> <p>The findings are:</p> <p>Review of the menu spreadsheets located in the dining room revealed:</p> <ul style="list-style-type: none"> -The facility offered a Regular diet, a Mechanical Soft diet, a No Added Salt diet, and 1800 Calorie Controlled Diabetic diet. -The menus did not include planned snack menus for the Regular, Mechanical Soft, No Added Salt, or 1800 Calorie Controlled Diabetic diets. -Three daily snacks were not listed as part of the menu developed by a Registered Dietitian for therapeutic diets. <p>Interview with the Co-Administrator on 06/07/16 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -The diabetic residents were served snacks at 10 a.m., 2 p.m., and 8 p.m. every day. -The non-diabetic residents were served snacks at 10 a.m., 3 p.m., and 8 p.m. every day. -She would have to find the snack menus for the facility. -Snacks were served to the residents by the Cook and the Personal Care Aides at the appointed times. <p>Interview with the Cook for the facility on 06/07/16 at 11:20 a.m. revealed:</p> <ul style="list-style-type: none"> -Diabetic residents were served snacks at 10 a.m., 2 p.m., and 8 p.m. every day. -All other residents were served snacks at 3 p.m. every day. -The facility did not have any snack menus. -The diabetic residents were given no added sugar applesauce, fresh fruit, and no sugar added canned fruits for snacks at the facility. -The other non-diabetic residents were served potato chips, crackers, and cookies for snacks at 	D 298		

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D 298	<p>Continued From page 67</p> <p>the facility. -The Personal Care Aides usually served the snacks at the facility.</p> <p>Interview with a resident on 06/07/16 at 3:45 p.m. revealed: -She was a diabetic. -She went to a day program usually from 9 a.m. to 1 p.m., Monday through Friday. -She received snacks 2 times a day about 3 p.m. and 7 p.m. -She was given chips and cookies for her snacks at the facility. -She got her last snack on 06/07/16 a little after 3 p.m. -She was not aware the facility was required to provide or offer snacks 3 times a day.</p> <p>Observation on 06/08/16 at 10:00 a.m. revealed: -A snack was given to a a diabetic resident at 10:00 a.m. by the Co-Administrator. -The resident received 1 slice of bread, 2 slices of cheese and 12 ounces of water. -No snacks were offered to the other 7 residents present in the facility at that time.</p> <p>Interview with a second resident on 6/8/16 at 10:07 a.m. revealed: -"I am hungry." -The resident only received cereal and water for breakfast the morning of 6/8/16. -"That's all they gave us."</p> <p>Interview with the same resident on 6/8/16 at 12:43 p.m. revealed: -Snacks were "mainly" offered at 3:00 p.m. -Sometimes he received snacks after breakfast. -He was unsure if they received snacks at night. -He was a diabetic. -He was on a low fat diabetic diet.</p>	D 298		

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D 298	<p>Continued From page 68</p> <ul style="list-style-type: none"> -He drank sodas "once in a while." -Sometimes he received juice and milk. -He did not have a problem with the diet. <p>Interview with a third resident on 06/08/16 at 12:55 p.m. revealed:</p> <ul style="list-style-type: none"> -He was not diabetic. -He never was offered a snack at 10 a.m. -Sometimes, he was offered a snack at 3 p. m. -Sometimes, he was offered a snack at 8 p.m. -He was not a big eater and snacks didn't matter to him. -He was not aware the facility was required to provide or offer snacks 3 times a day. <p>Interview with a fourth resident on 06/09/16 at 2:05 p.m. revealed:</p> <ul style="list-style-type: none"> -Snacks were sometimes offered at 3 p.m. and 8 p.m. at the facility. -Snacks offered were potato chips, candy, and water. -She normally kept her own snacks in her room. -She did not remember the last time the staff offered her a snack at the facility. -She was not aware the facility was required to provide or offer snacks 3 times a day. <p>Interview with a Personal Care Aide on 06/08/16 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Diabetic residents get snacks at 10 a.m., 2 p.m., and 8 p.m. every day. -Snacks are offered to all residents at 8 p.m. -Diabetic residents are given sugar-free applesauce and fresh fruits. -Non-diabetic residents are given chips, cookies, and peanut butter crackers for snack at the facility. -She was not aware the facility was required to provide or offer snacks 3 times a day. 	D 298		

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D 298	<p>Continued From page 69</p> <p>Interview with a second Personal Care Aide on 06/08/16 at 4:40 p.m. revealed:</p> <ul style="list-style-type: none"> -Sometimes the residents were offered a snack at 3 p. m. and 8 p.m. at the facility. -All diabetic residents were given snacks at 10 a.m. every day. -She wasn't sure about the other times snacks were offered to diabetic residents. -Residents were offered chips, cookies, sugar-free canned fruits, and fresh fruits for snacks. -The Personal Care Aides just gave the residents whatever was available at the facility. -She was not aware the facility was required to provide or offer snacks 3 times a day. <p>Interview with the Co-Administrator on 06/09/16 at 11:40 a.m. revealed:</p> <ul style="list-style-type: none"> -The facility did not have any snack menus for the residents in the facility. -She tried to limit the sweet snacks offered to the diabetic residents. -Diabetic residents were offered snacks 3 times a day. -Non-diabetic residents did not always get snacks 3 times a day. -Residents were given whatever was on hand at the facility for snacks like potato chips, cookies, 'nabs' (peanut butter crackers), or fruit if they had it. <p>Interview with the Administrator on 06/09/16 at 2:30 p.m. revealed:</p> <ul style="list-style-type: none"> -Diabetic residents were served snacks at 10 a.m., 2 p.m., and 9 p.m. every day. -Non-diabetic residents were only offered snacks at 3 p.m. and 8 p.m. daily. -She was not aware the facility was required to provide or offer snacks 3 times a day. -No residents had voiced concerns or complained 	D 298		

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D 298	Continued From page 70 about being hungry or not having snacks. -The facility did not have a snack menu for the residents. -She would have to contact the Registered Dietitian to get snack menus for the facility.	D 298		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve other beverages other than water to 9 of 9 residents during the meals. The findings are: Review of the "Weekly Menu Fall Cycle - Week 4" Regular diet lunch menu provided on 06/07/16 revealed 1/2 cup 2% milk, coffee or tea or decaffeinated coffee. Observation during the lunch meal on 6/7/16 at 12:05 p.m. revealed: -Eight residents were seated at the dining room table. -Seven of the residents only received 12 ounces (oz) of water as a beverage to drink. -One resident only received 12 oz of a diet soda to drink. -There was no milk, tea or coffee served.	D 306		

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D 306	<p>Continued From page 71</p> <p>Interview with the Co-Administrator on 6/7/16 at 12:30 p.m. revealed the residents were only served water with their meals unless the residents had their own drinks the residents had brought.</p> <p>Review of the "Weekly Menu Fall Cycle - Week 4" Regular diet dinner menu provided on 06/07/16 revealed the only beverage listed on the menu to be served was 1 cup of 2 % milk.</p> <p>Observation on 6/7/16 at 5:07 p.m. during the preparation of the dinner meal revealed the Co-Administrator and a personal care aide had poured seven glasses of water with ice and one glass with only ice.</p> <p>Interview with the Co-Administrator on 6/7/16 at 5:07 p.m. revealed: -The residents would only receive water with the dinner meal on 6/7/16. -She does not give the residents Koolaid or sodas much, because the residents urinated in the bed.</p> <p>Review of the "Weekly Menu Fall Cycle - Week 4" Regular diet breakfast menu provided on 06/08/16 revealed the residents were to be served 1 cup 2% milk and 1/2 cup grape juice.</p> <p>Observation of Resident #3 on 06/08/16 at 9:30 a.m. revealed: -Resident was served a late breakfast by his request. -Resident was given 12 ounces of milk, 12 ounces of water, and 4 ounces of grape juice.</p> <p>Interview with a resident on 6/8/16 at 10:07 a.m. revealed: -The only beverages the resident received for breakfast on 6/8/16 was milk for the cereal and</p>	D 306		

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D 306	<p>Continued From page 72</p> <p>water. -The resident did not complain about not receiving any other beverages.</p> <p>Interview with a second resident on 06/08/16 at 12:55 p.m. revealed: -The facility only served water to the residents during their meal times. -Sometimes he got coffee with his breakfast but not often. -He got coffee and water with his breakfast on 06/08/16.</p> <p>Review of the "Weekly Menu Fall Cycle - Week 4" Regular diet lunch menu provided on 06/08/16 revealed: -The residents was to be served 1 cup of a beverage. -The type of beverage was not listed on the menu.</p> <p>Observation during the lunch meal on 6/8/16 at 12:00 p.m. revealed 7 of 9 residents received 12 oz water and 12 oz tea for beverages.</p> <p>Observation on 6/8/16 at 5:08 p.m. revealed the Administrator, the Co-Administrator and another staff were preparing the dinner meal.</p> <p>Review of the "Weekly Menu Fall Cycle - Week 4" Regular diet dinner menu provided on 06/08/16 revealed there was no beverage listed on the menu.</p> <p>Interview with the Co-Administrator on 6/8/16 at 5:08 p.m. revealed: -All of the residents were only going to receive water with the dinner meal on 6/8/16 so the residents would not urinate in the bed. -She was not aware the residents were to receive</p>	D 306		

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D 306	<p>Continued From page 73</p> <p>beverages other than water with the meals.</p> <p>Observation on 6/8/16 at 5:15 p.m. revealed the Co-Administrator prepared 12 ounces of water and 12 ounces of tea with the meals.</p> <p>Review of the "Weekly Menu Fall Cycle - Week 4" Regular diet lunch menu to be provided on 6/9/16 revealed: -One cup of a beverage was listed on the menu to be served. -The type of beverage to be served was not listed on the menu.</p> <p>Observation of the lunch meal on 6/9/16 at 12:15 p.m. revealed 8 of 9 residents received 12 oz water and 12 oz Koolaid as beverages to drink.</p> <p>Interview with the Administrator on 6/9/16 at 3:25 p.m. revealed: -The residents received tea or Koolaid two to three times weekly with meals. -She was not aware residents were to be served other beverages and water during the meals.</p>	D 306		
D 317	<p>10A NCAC 13F .0905 (d) Activities Program</p> <p>10A NCAC 13F .0905 Activities Program</p> <p>(d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities.</p>	D 317		

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D 317	<p>Continued From page 74</p> <p>Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provided 14 hours of planned group weekly activities for 9 of 9 residents.</p> <p>The findings are:</p> <p>Observations during the survey from June 7-9, 2016 revealed: -The residents were watching television (TV) in the living room, sleep, outside on the porch or in a day program. -There were no activities being done during the survey.</p> <p>Review of the June 2016 Activity Calendar from 6/7/2016-6/9/2016 revealed: -The a.m. and p.m.'s were not listed on the calendar. -On 6/7/16, from 10-11., card games were to be offered; from 11:00-12:00 watching TV was to be offered; from 1-2 coloring was to be offered; 6-8 games were to be offered. -On 6/8/16, from 8-10 card games were to be offered; from 11-12 exercise was to be offered; from 1-2:30 watching soap operas was to be offered; from 6-7:30 bible study was to be offered. -On 6/9/16, from 9-10 sing along was to be offered; from 11-12 exercise was to be offered; from 1-3:30 watching soap operas was to be offered; from 6-8 games were to be offered..</p> <p>Observation of the activity supplies on 6/9/16 at</p>	D 317		

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D 317	<p>Continued From page 75</p> <p>12:48 p.m. revealed there were two puzzles on a table in the living room, two puzzles on a bookshelf in the hall at the front entrance door and a checkerboard on the table in the living room.</p> <p>Confidential interview with a resident revealed: -The residents colored and painted as activities "when they wanted to." -The facility did not take the residents on outing. -The resident had not told anyone about wanting to go on outings at the facility. -The last time the resident went on an outing was one month ago.</p> <p>Confidential interview with a second resident revealed: -The residents played Bingo at the facility. -The residents had not played Bingo in over one month. -Sometimes they had church at the facility. -They had not had church at the facility since last month (May 2016). -The facility did not take the resident anywhere, but to the doctor's office. -The resident's last outing was June 2016. -The resident went to the doctor at least every other month. -The Administrator does not take the residents shopping. -The resident wanted to go places. -The resident had not spoken to the Administrator about wanted to go on outings. -"I get tired of sitting here all week." -"I get tired of sitting around and watching TV."</p> <p>Confidential interview with a third resident on 06/07/16 at 3:40 p.m revealed: -No real activities were done at the facility with residents except for church services.</p>	D 317		

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D 317	<p>Continued From page 76</p> <ul style="list-style-type: none"> -Different groups from the community came and did church services with the residents about 1 to 2 times per month. -There was someone who use to come and set-up for the residents to play bingo. -No bingo had been played as part of activities for about least 2 months. -The resident did not know the facility had an activities calendar. -The resident did not know what activities were posted on the calendar for the residents. -The resident could not remember when the facility had taken the residents out for a group outing. -The resident only went on an outing if the resident had a doctor's appointment or if a family member came and picked the resident up to go out. <p>Confidential interview with a fourth resident on 06/09/16 revealed:</p> <ul style="list-style-type: none"> -The residents use to plan bingo with the Activity Director about 2 times a month. -She was not sure of the last time the Activity Director had been there to play bingo with the residents in the facility. -Sometimes, the Personal Care Aides played games with the residents. -Most of the time the staff was too busy to do activities with the residents so they just watched television. -There were no group outings except when residents had doctor's appointments and then the residents may go the local stores like the Dollar Tree or Family Dollar stores. -Staff took the residents to their doctor's appointments. <p>Interview with a Personal Care Aide on 06/08/16 at 4:40 p.m. revealed:</p>	D 317		

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D 317	<p>Continued From page 77</p> <ul style="list-style-type: none"> -Personal Care Aides do some activities with the residents sometimes. -Residents participated in a variety of activities like bingo, word games, coloring, drawing, and playing cards. -She could not recall the last time she had done activities with the residents. -The 2-3 residents went on outings outside of the facility when a resident had a doctor's appointment. -These outings occurred about 2 times a month. -Residents went to the Dollar Store and McDonald's on these outings. -No group outings were done with the residents at the facility. <p>Interview with the Co-Administrator on 06/07/16 at 11:00 a.m. revealed:</p> <ul style="list-style-type: none"> -The facility had an Activity Director who was not certified who came in and did activities with the residents 3-4 times a week. -She did not think that anyone else was certified to be an Activity Director at the facility. -She and the Administrator both work to put together the activities for the monthly calendar. -The staff did activities with the residents when the Activity Director was not available. <p>Interview with the Administrator on 06/07/16 at 1:15 p.m. revealed:</p> <ul style="list-style-type: none"> -The current Activity Director was not certified. -She had been certified as an Activity Director for at least 10 to 12 years. -She and other staff did activities with the residents when the Activity Director was not there in the facility. -Resident activities included bingo, card games, and watching television. <p>Interview with the Co-Administrator on 06/09/16</p>	D 317		

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D 317	<p>Continued From page 78</p> <p>at 11:40 a.m. revealed:</p> <ul style="list-style-type: none"> -Activities are planned to be provided for the residents. -Activities are not always done with the residents due to things happening in the facility. -Activities may not get done if the staff is too busy providing resident care. -Some residents do go out of the facility when residents have doctor's appointments. -The Administrator and Co-Administrator took the residents to all of their appointments. -There were no planned group outings for the residents at the facility. <p>Interview with the Administrator on 06/09/16 at 2:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The Activity Director and Administrator usually did the activities with the residents. -The Administrator and the Co-Administrator usually did the monthly calendar. -The activity calendar was made up of activities the residents liked to do. -The residents usually did the same activities all of the time. -The activities are determined by the residents. -The residents did not liked to exercise, play Bingo, play card games and watch TV. -There were no planned group outings because the residents didn't have any money to go out with. -The residents watched movies when a staff member [named] was scheduled to work at the facility. -Residents went out when they had a doctor's appointment and the staff may take them to the the local stores like the Dollar Tree and fast food restaurants McDonald's or Burger King. -The Administrator or the Co-Administrator were the only staff who took the residents to the doctor appointments. 	D 317		

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D 317	Continued From page 79 -Sometimes they took the residents riding after the doctor's appointment. -She could not recall the last time the residents had all gone out together on a group outing. -She does not document when the residents go on outings. -Co-Administrator took a resident shopping on last week 6/3/16 -Sometimes volunteers came in and did activities with the residents. -The last time volunteers came in to do activities was around last Christmas. -She evaluated the activities everytime the residents had done activities. -She had not documented the evaluation. -She was aware the residents wanted to do more activities. -The activities had not been done this week because the staff was busy with the survey process.	D 317		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based observations, interviews and record reviews, 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 water temperatures.	D912		

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D912	Continued From page 80 The findings are: Based on observations and interviews, the facility failed to assure the facility's water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 5 of 5 fixtures. [Refer to TagD113, 10A NCAC 13F .0311(d). (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure 2 of 2 sampled residents (#1, #2) were not neglected related to implementation of orders and infection control. The findings are: 1. Based on observation, record review, and interview, the facility failed to assure physician ordered blood sugar checks were done for 2 of 2 sampled residents (#1, #2). [Refer to TagD276, 10 NCAC 13F .0902 (c)(3-4). (Type B Violation)] 2. Based on observations, interviews and record review, the facility failed to assure the resident's blood sugar log was matching the resident's glucometers and Medication Administration Records (MARs) for 2 of 2 sampled residents (#1, #2). [Refer to TagD932, G.S. 131D-4.4A (b)(1) (a-f). (Type B Violation)]	D914		

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D932	Continued From page 81	D932		
D932	<p>G.S. 131D-4.4A (b) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements</p> <p>(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012:</p> <p>(1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following:</p> <ul style="list-style-type: none"> a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV,</p>	D932		

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D932	<p>Continued From page 82</p> <p>hepatitis B, hepatitis C, and other bloodborne pathogens.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record review, the facility failed to assure the resident's blood sugar log was matching the resident's glucometers and Medication Administration Records (MARs) for 2 of 2 sampled residents (#1, #2).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 02/26/16 revealed the resident's diagnoses included Schizo-Affective disorder, hypertension, diabetes type II with complications, obesity, and acid reflux.</p> <p>Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 06/25/14.</p> <p>Review of a Resident #1's physician's order dated 03/16/16 revealed: -Resident #1 needed a glucometer to check her blood once daily. -Goal of fasting glucose was 120 and postprandial 2 hours after meals was 140 to 160.</p> <p>Interview with Resident #1 on 06/07/16 at 4:00 p.m. revealed: -She knew she was diabetic. -The staff checked her blood sugar about 4 times a day.</p>	D932		

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D932	<p>Continued From page 83</p> <p>Review of Resident #1's June 2016 Medication Administration Record (MAR) revealed: -Check fasting blood sugars daily and 2 hours after breakfast at 7:30 a.m. and 10:00 a.m. -No blood sugar results were documented 06/01/16 through 06/08/16.</p> <p>Review of Resident #1's May 2016 MAR revealed: -Check fasting blood sugars daily and 2 hours after breakfast at 7:30 a.m. and 10:00 a.m. -No blood sugar results were documented 05/01/16 through 05/31/16.</p> <p>Review of Resident #1's April 2016 MAR revealed: -Check fasting blood sugars daily and 2 hours after breakfast at 7:30 a.m. and 10:00 a.m. -There were 14 blood sugar readings documented from 04/09/16 through 04/29/16 and ranged 69 to 99.</p> <p>Interview with the Administrator on 06/08/16 at 12:45 p.m. revealed she was unable locate the March 2016 Medication Administration Record (MAR) for Resident #1.</p> <p>Observation of the Co-Administrator on 06/09/16 at 06:00 p.m. revealed: -The Co-Administrator removed a black zippered pouch with a glucometer and lancing pen from the top drawer on the medication cart. -The outside of the black pouch removed from the medication care was labeled with Resident #1's name. -The glucometer and lancet inside of the black pouch were not labeled with Resident #1's name. -Another black zippered pouch that contained a glucometer and lancing pen was also in the top</p>	D932		

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D932	<p>Continued From page 84</p> <p>drawer of the medication cart.</p> <p>Review of the June 2016 memory of the glucometer staff identified as belonging to Resident #1 on 06/09/16 at 7:05 p.m. revealed:</p> <ul style="list-style-type: none"> -The glucometer was programmed with the correct date and time. -There were no blood sugar readings for the month of June 2016 in the memory of the glucometer for Resident #1. <p>Review of the May 2016 history for the glucometer which staff identified as belonging to Resident #1 revealed:</p> <ul style="list-style-type: none"> -There were 30 blood sugar readings for May 2016 that ranged from 72 to 228. -There was 1 blood sugar reading on 05/12/16 at 5:54 p.m. that was 180. -There were 2 blood sugar readings on 05/08/16: 147 at 7:29 a.m. and 208 at 6:07 p.m. -There were 3 blood sugar readings on 05/07/16: 98 at 6:05 p.m., 122 at 2:40 p.m. and 208 at 6:07 p.m. -There were 3 blood sugar readings on 05/03/16: 146 at 7:05 a.m., 228 at 6:07 p.m., and 88 at 7:21 p.m. -There were 2 blood sugar readings on 05/01/16: 110 at 5:22 a.m. and 83 at 5:33 a.m. <p>Review of the April 2016 history for the glucometer which staff identified as belonging to Resident #1 revealed:</p> <ul style="list-style-type: none"> -There were 15 blood sugar reading for April 2016 that ranged from 69 to 219. -There were 2 blood sugar readings on 04/29/16: 128 at 4:28 a.m. and 69 at 5:34 a.m. -There were 2 blood sugar readings on 04/09/16: 141 at 4:55 a.m. and 80 at 6:09 a.m. -There were 2 blood sugar readings on 04/04/16: 94 at 6:07 a.m. and 166 at 6:08 a.m. 	D932		

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NAME OF PROVIDER OR SUPPLIER TWIN OAKS AND TWINS ADULT HOME	STREET ADDRESS, CITY, STATE, ZIP CODE BLDG # 817 HIGHWAY 258 NORTH COMO, NC 27818
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D932	<p>Continued From page 85</p> <p>Review of the March 2016 history for the glucometer which staff identified as belonging to Resident #1 on 06/09/16 at 7:13 p.m. revealed: -There were 21 blood sugar readings for March 2016 ranged from 75 to 224. -There were 2 blood sugar readings on 03/21/16: 79 at 6:10 a.m. and 119 at 6:20 a.m. -There were 2 blood sugar readings on 03/20/16: 134 at 6:13 a.m. and 82 at 6:27 a.m. -There were 2 blood sugar readings on 03/19/16: 75 at 6:17 a.m. and 122 at 6:18 a.m.</p> <p>Review of Resident #1's glucometer results and the facility blood sugar logs revealed: -There was a glucometer reading of 180 on 05/12/16 at 5:54 p.m. and a blood sugar of 160 was documented on the facility blood sugar log at 7:00p.m. -There was no glucometer reading on 05/12/16 in the a.m. and a blood sugar of 88 was documented on the facility blood sugar log at 7:00 a.m. -There was no glucometer reading on 05/10/16 and a blood sugar of 87 was documented on the facility blood sugar log at 7:00 a.m. -The glucometer reading of 147 on 05/08/16 at 7:29 a.m. and 88 on the facility blood sugar log at 7:00 a.m. -There were 2 glucometer reading on 04/04/16 of 94 at 6:07 a.m., 166 at 6:08 a.m., and the blood sugar was documented as 84 at 7:00 a.m. on the facility blood sugar log. -There was a glucometer reading of 106 on 03/18/16 at 6:13 p.m. and documented as 190 on the facility blood sugar log at 7:00 p.m.</p> <p>Review of Resident #1's blood sugar log and glucometer results revealed 13 out of 66 opportunities, the FSBS from the blood sugar log</p>	D932		

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D932	<p>Continued From page 86</p> <p>and glucometer was not matching.</p> <p>Interview with a Medication Aide on 06/08/16 at 4:40 p.m. revealed:</p> <ul style="list-style-type: none"> -She thought Resident #1 was supposed to have her blood sugar twice a day. -Resident #1 had the order for blood sugar checks for about 2 months. -She documented the blood sugar results on the MAR for Resident #1 and on the facility's blood sugar logs. -She was not aware the blood sugar readings for Resident #1 were not matching between the glucometer history, the MARs, and the facility blood sugar record. -She did not know why the glucometer for Resident #1 had numerous blood sugar readings with close proximity times and dates. -The glucometers were not shared amongst the residents of the facility. <p>Interview the Administrator on 06/09/16 at 2:30 p.m. revealed:</p> <ul style="list-style-type: none"> -She thought Resident #1 was supposed to have her blood sugar checked twice a day. -She had reviewed the physician's order written 03/16/16 and realized Resident #1 was only supposed to have her blood sugar checked once a day. -She would call the facility pharmacy to clarify the order on the MAR. -It was expected for staff to check the blood sugar of Resident #1 daily. -The Medication Aides were supposed to document the blood sugar results on the facility's blood sugar record and on the MAR for the Resident #1. -She was not aware the blood sugar readings for Resident #1 were not matching between the glucometer history, the MARs, and the facility 	D932		

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D932	<p>Continued From page 87</p> <p>blood sugar record.</p> <p>Interview with the Co-Administrator on 06/09/16 at 6:00 p.m. revealed:</p> <ul style="list-style-type: none"> -Every resident who had physician's orders for blood sugar testing had their own glucometer, lancing pen, and their own supply of glucometer blood strips and lancets. -The glucometers and lancing pen devices were not supposed to be shared. -It was expected for the Medication Aides to document the blood sugar results on the MAR and the facility's blood sugar record form. -She was not aware there was problem with Resident #1's blood sugars not being documented on the MAR and the facility's blood sugar record from the glucometer reading. <p>2. Review of Resident #2's current FL-2 dated 9/1/15 revealed the resident had diagnoses of schizophrenia disorder and mild retardation.</p> <p>Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 10/16/14.</p> <p>Review of Resident #2's physician's orders included an order dated 5/17/16 to check the resident's finger stick blood sugars (FSBS) twice daily.</p> <p>Review of Resident #2's blood sugar log revealed the FSBS were documented from 5/17/16 to 6/9/16 and were on the same log.</p> <p>Review of Resident #2's blood sugar log and glucometer results received on 6/9/16 revealed 16 out of 41 opportunities, the FSBS from the blood sugar log and glucometer were not matching.</p>	D932		

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D932	<p>Continued From page 88</p> <p>Observation of Resident #2's glucometer readings on 6/9/16 at 7:06 p.m. revealed: -The a.m. FSBS ranged from 166-384. -The p.m. FSBS ranged from 134-500.</p> <p>Review of Resident #2's blood sugar log and the glucometer results revealed: -On 6/9/16 at 7:30 a.m., FSBS was 191 on the blood sugar log. There was no FSBS reading on the glucometer for the 7:30 a.m. FSBS. -On 6/8/16 at 7:30 a.m., FSBS was 182 and at 5:00 p.m. was 182 on the blood sugar log. There were no FSBS readings on the glucometer for the 7:30 a.m. and 5:00 p.m. FSBS. -On 6/7/16 at 7:30 a.m., FSBS was 155 and at 5:00 p.m. was 116. There were no FSBS readings on the glucometer for the 7:30 a.m. and 5:00 p.m. FSBS. -On 6/6/16 at 7:30 a.m., FSBS was 186 on the blood sugar log. There was no FSBS documented at 5:00 p.m. on the log. There were no FSBS readings on the glucometer for the 7:30 a.m. and 5:00 p.m. FSBS. -On 6/5/16 at 7:30 a.m., FSBS was 185 on the blood sugar log. There was no FSBS documented at 5:00 p.m. on the log. There were no FSBS readings on the glucometer for the 7:30 a.m. and 5:00 p.m. FSBS. -On 5/31/16 at 7:30 a.m., FSBS was 180 on the blood sugar log. The glucometer results at 6:08 a.m. was 166. -On 5/30/16 at 7:30 a.m., FSBS was 186 on the blood sugar log. The glucometer results at 5:31 a.m. was 159 and at 6:09 a.m. was 183. -On 5/29/16 at 7:30 a.m., FSBS was 182 and at 5:00 p.m. was 230 on the blood sugar log. The glucometer results at 7:39 a.m. was 384. -On 5/28/16 at 5:00 p.m., FSBS was 215 on the blood sugar log. There was no FSBS readings on the glucometer for the 5:00 p.m. FSBS.</p>	D932		

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D932	<p>Continued From page 89</p> <p>-On 5/26/16 at 7:30 a.m., FSBS was 319 and at 5:00 p.m. was 282 on the blood sugar log. The glucometer results at 7:20 a.m. was 167 and at 4:10 p.m. was 274.</p> <p>-On 5/24/16 at 7:30 a.m., on 5/23/16 at 7:30 a.m. and at 5:00 p.m. and on 5/22/16 at 7:30 a.m. and at 5:00 p.m. revealed there was no documentation of FSBS in the log and there was no readings in the glucometer.</p> <p>-On 5/21/16 at 5:00 p.m., FSBS was 293. The glucometer results at 3:16 p.m. was 134.</p> <p>Interview with Resident #2 on 6/8/16 at 12:43 p.m. revealed: -Staff did not take the residents blood sugars daily. -"They take it every once in a while."</p> <p>Telephone interview with Resident #2's primary care physician's nurse on 6/8/16 at 1:45 p.m. revealed the resident had an order dated 5/17/16 to take blood sugars twice daily.</p> <p>Interview with the Co-Administrator on 6/9/16 at 6:11 p.m. revealed Resident #2 and the other resident who had FSBS had their own blood glucose monitoring kit.</p> <p>Observation on 6/9/16 at 6:11 p.m. revealed: -The Co-Administrator pulled Resident #2's glucose monitoring kit out of the Administrator's office desk drawer. -The glucose monitoring kit case, the glucometer, the lancets and the lancets device did not have the resident's name on it. -The glucose monitoring strip label was dated 5/17/16. It listed the residents name and revealed there were 50 test strips. The instructions revealed use one strip to test blood sugars for poor diabetes control. There were four</p>	D932		

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D932	<p>Continued From page 90</p> <p>refills.</p> <p>Two MA's who took Resident #2's blood sugars could not be reached by the end of the survey.</p> <p>Interview with Administrator on 6/9/16 at 7:00 p.m. revealed she did not know why some of Resident #2's FSBS on the blood sugar log was not matching the glucometers.</p> <p>_____</p> <p>The facility submitted a Plan of Protection dated 6/16/16, as follows:</p> <ul style="list-style-type: none"> -The Administrators will label the diabetics glucometers, lancets, glucose monitoring strips and glucose monitoring kit. -The Administrators will observe the accuracy of staff checking resident blood sugars, glucometer readings and documentation daily. -The Administrators will develop an infection control policy. -Staff will have a training on infection control. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 24, 2016</p>	D932		
D992	<p>G.S. § 131D-45 (a) 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</p>	D992		

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D992	<p>Continued From page 91</p> <p>Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on interviews and record review the facility failed to assure 1 of 1 Staff (B) received a drug screening before hired.</p> <p>The findings are:</p> <p>Review of Staff B's, Medication Aide (MA)/Personal Care Aide (PCA), personnel file revealed: -She was hired to work at the facility 4/2/14. -There was no documentation of a drug</p>	D992		

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D992	<p>Continued From page 92</p> <p>screening.</p> <p>Interview with the Administrator on 6/9/16 at 12:05 p.m. revealed:</p> <ul style="list-style-type: none"> -She kept up with staff personnel files. -She checked staff qualifications every 10 months to 1 year. -She had not checked staff qualifications in the past 12 months. -She thought Staff B had completed the drug screening upon hire, but she could not remember if it was completed or not. -Six months ago, she told all of her staff to have a drug screening completed. -She did not check to see if Staff B had completed the drug screening. <p>Staff B was not available for interview.</p>	D992		