

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL011350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND TERRACE FAMILY CARE HOME # 7</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 ELLA LANE</b> <b>ALEXANDER, NC 28701</b>
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C 000	Initial Comments  The Adult Care Licensure Section and the Buncombe County DSS conducted an annual and follow-up survey on July 6, 2016 with a telephone exit conference on July 7, 2016.	C 000		
C 034	<p>10A NCAC 13G .0302(n) Design and Construction</p> <p>10A NCAC 13G .0302 Design and Construction (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.</p> <p>This Rule is not met as evidenced by: Based on interviews, the facility failed to assure they had a current fire and building safety inspection report revealing it was six months overdue.</p> <p>The findings are:</p> <p>Interview with the Administrator on 1:00pm revealed: -He could not find documentation of any fire inspection for this facility. -He knew there was a current inspection when he took over this facility in August 2015. -He thought the local fire department inspectors came out voluntarily and that he did not have to call them to request an inspection.</p> <p>Telephone interview with a receptionist at the fire department on 7/6/16 at 1:20pm revealed: -They had not inspected this facility since 12/9/14. -The facility should have called for another inspection in December 2015. -The facilities are supposed to call to request an</p>	C 034		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 034	Continued From page 1  inspection. -Since the Administrator requested an inspection during the survey on 7/6/16, they would schedule a visit for the inspection.  Telephone interview with the Administrator on 7/7/16 at 11:25am revealed the fire inspection was scheduled for "today, on" 7/7/16 at 1:00pm.	C 034		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings  10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home 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 homes.  This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was maintained clean, uncluttered, and free of all hazards as evidenced by a bathroom sink loose from the wall, a detached resident bed frame, a loose curtain rod, a dresser with missing knobs, a broken slat in a blind, dusty ceiling vents, soiled mattresses for two of six residents, and 3 of 6 resident rooms, the dining room, and kitchen which were in need of cleaning.  The findings are:  Observation of the facility on 7/6/16 during initial tour from 9:15am to 10:30am revealed: -The facility had 3 bathrooms and 6 resident	C 078		

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C 078	<p>Continued From page 2</p> <p>rooms.</p> <p>-The first bathroom on the right was locked, but after the Supervisor-in-Charge (SIC) unlocked the door, the sink was observed to be loose from the wall about 2 inches and leaning downward.</p> <p>Interview with the SIC on 7/6/16 at 9:30am revealed:</p> <p>-He locked the bathroom because the sink had been loose for at least one week.</p> <p>-He had forgotten to fill out a maintenance requisition form for the sink.</p> <p>Telephone interview with the Administrator on 7/7/16 at 3:00pm revealed:</p> <p>-His maintenance staff had already attached the sink to the wall.</p> <p>-He was not aware the sink was loose from the wall until 7/6/16 during the survey.</p> <p>Observation on 7/6/16 at 9:20am of the last bedroom on the right where Resident # 3 resided revealed:</p> <p>-The bedframe was disconnected from the rail on the left side with two screw holes where it had been attached.</p> <p>-There were no loose screws on the floor.</p> <p>-The right side of the one piece curtain on the window was hanging lower than the left side.</p> <p>-A large television was sitting on the floor and was covered with a thick layer of dust.</p> <p>-The cloth mattress had no sheets on it and had brown soiled areas all over the top of the mattress.</p> <p>-The pillowcase on the one pillow was stained with dirty brown areas.</p> <p>-The floor was dirty with lint and dust.</p> <p>Interview with Resident #3 on 7/6/16 at 9:20am revealed:</p>	C 078		

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C 078	<p>Continued From page 3</p> <p>- "Don't touch that curtain, it will fall." - He did not know how long the bed frame had been disconnected from the rail and he did not know how long the curtain rod had been loose. - He said his sheets were in the washer. - He did not know why he did not have a clean pillow case. - He said he cleaned his own room. - He had no concerns or complaints related to the physical environment or his care at the facility.</p> <p>Interview with the SIC on 7/6/16 at 11:30am revealed: - He was not aware the bed frame was disconnected from the rail. - He was not aware the curtain rod was loose. - He did not know why Resident #3's pillowcase was so dirty.</p> <p>Observation on 7/6/16 at 9:45am of the first Resident Room on the left where Resident #1 resided revealed: - The bookcase had a thick layer of dust on top and on each shelf. - The chest of drawers was covered with a layer of dust, the 5 drawers were open and hanging forward and all the knobs were missing. - The cloth mattress had no sheets on it and had brown soiled areas all over the top of the mattress. - A dirty soiled pillow on the bed had no pillow case. - The floor which included under the bed, was covered with dust and lint and had loose tobacco, debris, 2 food wrappers, a pair of socks, a magazine, 2 books, dirty spots, an empty soda can, and trash. - There were clothes under the bed. - The blinds had a piece of slat broken off at least 5 inches long.</p>	C 078		

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C 078	<p>Continued From page 4</p> <p>Interview with Resident #1 on 7/6/16 at 9:45am revealed: -His sheets were in the dresser drawers. -He needed to clean his room, but he had been really busy.</p> <p>Interview with the SIC on 7/6/16 at 11:30am revealed: -Resident #1 would take off dresser knobs if he put them on. -Resident #1 usually takes the sheets off and puts them in the closet and will not leave them on the bed.</p> <p>Observation on 7/6/16 at 9:45am of the 2nd Resident Room on the left side of the hallway where Resident #2 resided revealed the small refrigerator, dresser, and bookcase were all very dusty.</p> <p>Interview with Resident #2 on 7/6/16 at 9:45am revealed he had no concerns related to the physical environment.</p> <p>Observation of the 2 ceiling return air vents in the hallway on 7/16/16 at 9:50am revealed they were entirely covered with a layer of heavy dust.</p> <p>Observation of the dining room floor on 7/6/16 at 10:20am revealed dried brown soiled stained circles at least 6 inches in diameter on the tile in the area of the coffee pot.</p> <p>Observation of the kitchen floor on 7/6/16 at 10:30am revealed small dried soiled brown stained circles on the tile.</p> <p>Observation of the living room and dining room on 7/6/16 at 9:15am revealed the SIC was</p>	C 078		

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C 078	<p>Continued From page 5</p> <p>mopping those areas and the floors were wet.</p> <p>Observation of the linen closet on 7/6/16 at 11:45am revealed at least 2 unfolded sheets piled on a shelf and at least 7 folded pillowcases on another shelf.</p> <p>Interview with the SIC on 7/6/16 at 11:30am revealed: -He was not aware the residents' mattresses were that dirty. -He cleaned Resident #1 and #3's room 2x per week but the other residents liked to clean their own room. -He forgot to report the broken sink to management. -He would start monitoring all the resident rooms and cleaning them daily. -He had not filled out any maintenance requests for the dresser knobs or the bed frame.</p> <p>Telephone interview with the Administrator on 7/7/16 at 3:00pm revealed: -He had not been monitoring the facility routinely, only to visit the residents. -The SICs were supposed to clean routinely and be responsible for assuring the rooms were maintained clean and that furniture was maintained in good repair. -He was not aware the mattresses were dirty. -He was not aware the residents' rooms were in need of cleaning. -He planned to conduct routine visits to the facility to look at the physical environment at least 2 times per week. -He had ordered 4 new mattresses. -The SIC was supposed to fill out maintenance requisitions and give to the maintenance staff for items which needed repairing like the dresser with no knobs and the bed frame.</p>	C 078		

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C 102	<p>10A NCAC 13G .0317 (a) Building Service Equipment</p> <p>10A NCAC 13G .0317 Building Service Equipment</p> <p>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the lights in the hallway were maintained in a safe and in an operating condition.</p> <p>The findings are:</p> <p>Observation on 7/6/16 at 9:15am of the hallway revealed: -The light switch in the hallway was duct taped in the off position. -None of the six hallway lights were on, only a night light.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 7/6/16 at 9:15am revealed: -When the lights in the hallway were switched on, it would trip the breaker. -They had an electrical storm recently and it may have damaged the lights. -He told the maintenance staff about the lights tripping the breaker "about 2 weeks ago."</p> <p>Interview with the maintenance staff on 7/6/16 at 12:45pm revealed:</p>	C 102		

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C 102	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>-He called an electrician "about 2 weeks ago" but the electrician was very busy and had not had time to come.</li> <li>-The electrician was supposed to notify him when he could come.</li> <li>-He had not discussed the hallway lights with the Administrator.</li> </ul> <p>Interview with the Administrator on 7/6/16 at 1:35pm revealed:</p> <ul style="list-style-type: none"> <li>-He was not aware the hallway lights were out of order before the survey.</li> <li>-He does not routinely walk through the building to look at physical environment, but comes to talk to the residents sometimes.</li> <li>-He was in the facility on July 4, 2016 but the light switch was not duct taped.</li> <li>-The SIC should have filled out a maintenance requisition form and given it to the maintenance staff.</li> <li>-The maintenance staff should assess the problem, get a cost estimate if needed, and contact the Administrator.</li> <li>-No one had contacted him about the hallway lights.</li> </ul> <p>Telephone interview with the SIC on 7/7/16 at 9:50am revealed:</p> <ul style="list-style-type: none"> <li>-The electrician came on 7/6/16 and repaired a light in the hallway.</li> <li>-After the electrician fixed the hallway light, turning the light switch on no longer tripped the breaker.</li> </ul> <p>Telephone interview with the Administrator on 7/7/16 at 11:25am revealed:</p> <ul style="list-style-type: none"> <li>-The electrician found a light bulb in the hallway light fixture which was cracked that had caused the problem.</li> <li>-The electrician removed the cracked bulb and</li> </ul>	C 102		

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C 102	<p>Continued From page 8</p> <p>replaced it with a new bulb and the problem was solved.</p> <p>_____</p> <p>The Plan of Protection provided by the facility on 7/6/16 revealed:</p> <ul style="list-style-type: none"> <li>-The facility has scheduled an electrician to come out to the facility today, 7/6/16, to fix the problem with the light switch and breaker box to avoid any issues that reoccur.</li> <li>-The Administrator will monitor any concerns the residents have and will put up caution signs stating the light switch is causing the breaker to pop.</li> <li>-The Supervisor-in-Charge will contact the Administrator immediately when maintenance issues occur.</li> </ul> <p>THE DATE OF CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 21, 2016.</p>	C 102		
C 246	<p>10A NCAC 13G .0902(b) Health Care</p> <p>10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up to meet the routine and acute health care needs for 1 of 3 residents sampled (Resident #2) related to medication refusal of gabapentin.</p> <p>The findings are:</p>	C 246		

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C 246	<p>Continued From page 9</p> <p>Review of current FL2 for Resident #2, dated 12/29/15, revealed diagnoses included cognitive impairment, depression, and history of substance abuse.</p> <p>Review of physician orders, dated 4/19/16, for Resident #2 revealed gabapentin 100 mg three times per day for pain.</p> <p>Observations of medications on hand for administration for Resident #2 on 7/6/16 at 11:30am revealed an empty medication bottle labeled 42 tablets gabapentin 100 mg three times per day dispensed on 4/19/16.</p> <p>Forty-two tablets gabapentin 100 mg three times per day was a 12 day supply if administered as ordered.</p> <p>Review of the April through June 2016 MARs Medication Administration Record revealed gabapentin 100 mg was documented three times per day from 4/19/16 through 7/6/16.</p> <p>Interview with the Supervisor-in-Charge on 7/6/16 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was hospitalized from 4/12/16 to 4/17/16 with a ruptured hernia and upon discharge, the physician ordered the gabapentin 100 mg three times per day for pain.</li> <li>-Resident #2 had been refusing the gabapentin, but he had never documented the refusals.</li> <li>-Resident #2 would usually only take 1 gabapentin 100mg per day, not three times per day.</li> <li>-The gabapentin ran out around the first of June 2016 and he had not requested refills nor called the prescribing physician because Resident #1 did not like to take the medication.</li> <li>-He had documented the administration of</li> </ul>	C 246		

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C 246	<p>Continued From page 10</p> <p>gabapentin 100 mg three times per day in error when gabapentin 100 mg was not available and when Resident #2 only took 1 per day.</p> <p>-He had not called the physician to notify him of the refusal of the gabapentin and he had not called the pharmacy for a refill.</p> <p>-He did not notify the Administrator that Resident #2 was refusing the gabapentin.</p> <p>Interview with Resident #2 on 7/6/16 at 1:15pm revealed:</p> <p>-He did not like to take the gabapentin because of the way it made him feel.</p> <p>-He discussed his refusals with the physician but the physician was new to the practice, not familiar with his diagnoses, and refused to discontinue the gabapentin.</p> <p>-He did have a lot of pain but he was on other medications for the pain.</p> <p>Telephone interview with staff at the physician office on 7/6/16 at 1:50pm revealed:</p> <p>-They were not aware Resident #1 was refusing the gabapentin 100 mg three times per day.</p> <p>-They were sending out a refill today of gabapentin 100 mg three times per day and staff were to let them know if Resident #2 refused the medication.</p> <p>Interview with the Administrator on 7/6/16 at 1:35pm revealed:</p> <p>-The SICs were supposed to notify him immediately if residents refused their medications.</p> <p>-He was not aware Resident #2 had ran out of or had been refusing gabapentin.</p> <p>-Their policy was to review MARs for accuracy once a week and compare them to medications on hand.</p> <p>-He had not monitored medications recently as he</p>	C 246		

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C 246	Continued From page 11  should because he had been busy and occasionally had to provide relief staff at some of his facilities because of staffing shortages. -He was going to start monitoring medications, MAR's, and medication orders at least 2 times per week.	C 246		
C 342	10A NCAC 13G .1004(j) Medication Administration  10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the Medication Administration Record was accurate for 1 of 3 residents sampled (Resident #2) related to documenting the refusals and no availability of	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL011350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/07/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND TERRACE FAMILY CARE HOME # 7</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>19 ELLA LANE</b> <b>ALEXANDER, NC 28701</b>
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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
C 342	<p>Continued From page 12</p> <p>gabapentin.</p> <p>The findings are:</p> <p>Review of current FL2 for Resident #2, dated 12/29/15, revealed diagnoses included cognitive impairment, depression, and history of substance abuse.</p> <p>Review of physician orders, dated 4/19/16, for Resident #2 revealed gabapentin 100 mg three times per day for pain.</p> <p>Observations of medications on hand for administration for Resident #2 on 7/6/16 at 11:30am revealed an empty medication bottle labeled 42 tablets gabapentin 100 mg three times per day dispensed on 4/19/16.</p> <p>Review of the April through June 2016 Medication Administration Record (MARs) revealed gabapentin 100 mg three times per day was documented as administered daily from 4/19/16 through 7/6/16 with no refusals or medication not available noted.</p> <p>Interview with the Supervisor-in-Charge on 7/6/16 at 11:30am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was hospitalized from 4/12/16 to 4/17/16 with a ruptured hernia and upon discharge, the physican ordered the gabapentin 100 mg three times per day for pain.</li> <li>-Resident #2 had been refusing the gabapentin, but he had never documented the refusals.</li> <li>-Resident #2 would usually only take 1 gabapentin 100mg per day, not three times per day.</li> <li>-The gabapentin ran out around the first of June 2016 and he had not requested refills nor called the prescribing physician because Resident #2</li> </ul>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL011350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/07/2016</b>
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C 342	<p>Continued From page 13</p> <p>did not like to take the medication.</p> <ul style="list-style-type: none"> <li>-He had documented the administration of gabapentin 100 mg three times per day in error when gabapentin 100 mg was not available and when Resident #2 only took 1 per day.</li> <li>-He had not called the physician to notify them of the refusal of the gabapentin and he had not called the pharmacy for a refill.</li> <li>-He did not notify the Administrator that Resident #2 was refusing the gabapentin.</li> <li>-There was no documentation facility staff had notified the physician of Resident #2's refusal of the gabapentin.</li> </ul> <p>Interview with Resident #2 on 7/6/16 at 1:15pm revealed:</p> <ul style="list-style-type: none"> <li>-He did not like to take the gabapentin because of the way it made him feel.</li> <li>-He discussed his refusals with the physician but the physician was new to the practice, not familiar with his diagnoses, and refused to discontinue the gabapentin.</li> <li>-He did have a lot of pain but he was on other medications for the pain.</li> </ul> <p>Telephone interview with staff at the Resident #2's physician office on 7/6/16 at 1:50pm revealed:</p> <ul style="list-style-type: none"> <li>-They were not aware Resident #2 was refusing the gabapentin 100 mg three times per day.</li> <li>-They were sending out a refill today of gabapentin 100 mg three times per day and staff were to notify them if he refused it.</li> </ul> <p>Interview with the Administrator on 7/6/16 at 1:35pm revealed:</p> <ul style="list-style-type: none"> <li>-The SICs were supposed to notify him immediately if residents refused their medications.</li> <li>-He was not aware Resident #2 had ran out of or</li> </ul>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL011350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/07/2016</b>
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C 342	Continued From page 14  had been refusing gabapentin. -Their policy was to notify the physician for any medication refusals. -Their policy was to review MARs for accuracy once a week and compare them to medications on hand. -He had not monitored medications recently as he should because he had been busy and occasionally had to provide relief staff at some of his facilities because of staffing shortages. -He was going to start monitoring medications, MARs, and medication orders at least 2 times per week.	C 342		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights  G.S. 131D-21 Declaration of Resident's 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 on observations, interviews, and record reviews, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to building service equipment.  The findings are:  Based on observations and interviews, the facility failed to assure the lights in the hallway were maintained in a safe and in an operating condition. [Refer to Tag 102 10A NCAC 13G .0317(a) Building Service Equipment (Type B	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL011350</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/07/2016</b>
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C 912	Continued From page 15 Violation).]	C 912		