

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHESTNUT PARK REST HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 64 CHESTNUT PARK DRIVE WAYNESVILLE, NC 28786
---	--

(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	D 000		
D 074	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep clean 4 of 7 ceiling fans and 6 of 6 portable fans in resident rooms and common areas.</p> <p>The findings are:</p> <p>Observation on 7/20/16 at 9:00AM of the kitchen revealed: -The ceiling fan, located over the sink and end of the center counter, was off. -The blades on the fan had a thick coating of dust.</p> <p>Observation on 7/20/16 at 11:10AM of resident room #1 revealed: -The ceiling fan was on and temporarily shut off for the observation with a thick coating of dust on the blades. -Two window fans, each in windows over headboards of resident beds, with a thick coating of dust on the protective grill. -A personal fan in a window in the vicinity of a resident's bed with a thick coating of dust on the</p>	D 074		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHESTNUT PARK REST HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 64 CHESTNUT PARK DRIVE WAYNESVILLE, NC 28786
---	--

(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 074	<p>Continued From page 1</p> <p>protective grill.</p> <p>Observation on 7/20/16 at 11:25AM of resident room #3 revealed: -An oscillating floor fan next to a resident's bed was on, with the rear protective grill covered in a thick coat of dust. -Another oscillating floor fan next to another resident's bed was off, with the rear protective grill covered in a thick coat of dust. -A third oscillating floor fan near the door to the room was off, with the rear protective grill covered in a thick coat of dust.</p> <p>Observation on 7/20/16 at 4:50PM of the combined living room/dining area revealed: -Two ceiling fans were on and shut off temporarily for the observation, with a build-up of dust along the leading edges of the fan blades.</p> <p>6 of 6 interviewed residents revealed no complaints regarding the cleanliness of the facility.</p> <p>Interview on 7/20/16 at 5:15PM with the Administrator revealed: -Staff were expected to clean fans every two weeks. -The ceiling fan in the kitchen would not come clean. -She expected staff to complete this task and document it on cleaning forms but no cleaning forms were located at the time of the interview.</p>	D 074		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHESTNUT PARK REST HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 64 CHESTNUT PARK DRIVE WAYNESVILLE, NC 28786
---	--

(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
D912	<p>Continued From page 2</p> <p>adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to replace a dirty face mask, medication reservoir and tubing for a nebulizer machine for 1 of 1 residents requiring daily inhaled medications (Resident #3).</p> <p>The findings are:</p> <p>A. Review of Resident #3's most current FL-2 dated 6/30/16 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD). -Continuous oxygen at 3 liters/minute. -An order for ipratropium/albuterol solution by inhalation (a bronchodilator), the contents of one vial every 6 hours. -An admission date of 8/23/88 (1988).</p> <p>Review of Resident #3's most current Licensed Health Professional Support (LHPS) note dated 6/22/16 revealed care tasks included use of oxygen and a nebulizer.</p> <p>Review of an undated and handwritten statement from staff at a "sister" facility (provided by the Administrator) revealed "a mask with canula [sic]" was provided on 6/28/16 from the sister facility's overstock and in the past they had also provided "nebulizer replacement kits."</p> <p>Observation on 7/20/16 at 11:30AM of Resident #3 revealed: -Resident #3 awake and laying in his bed,</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHESTNUT PARK REST HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 64 CHESTNUT PARK DRIVE WAYNESVILLE, NC 28786
---	--

(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
D912	<p>Continued From page 3</p> <p>wearing nasal cannula oxygen tubing.</p> <ul style="list-style-type: none"> -The oxygen tubing was clean and attached to an oxygen concentrator at his bedside, which was set at 3 liters per minute. -On a dresser next to his bed was a black nebulizer machine and a tan colored nebulizer machine. -Laying on top of the tan colored nebulizer was an oxygen face mask with a medication reservoir and tubing (the mask, reservoir and tubing were collectively referred to as a nebulizer kit). -The inside of the face mask was dirty with bits of brown debris and a greasy residue. -The medication reservoir had dirt in exterior crevices and a small amount of clear liquid inside, with bits of brown debris also inside the reservoir. -The inside of the tubing had spots of brown staining. -There was no date label attached to the nebulizer kit. <p>Interview on 7/20/16 at 11:30AM with Resident #3 revealed he had last used his nebulizer that same morning.</p> <p>Observation on 7/20/16 at 12:05PM of the afternoon medication pass revealed:</p> <ul style="list-style-type: none"> -The Supervisor/Medication Aide was observed removing ipratropium/albuterol solution for inhalation, 3 ml amount from the medication cart and handing it to the Administrator at Resident #3's bedside for administration. -The Administrator picked up the nebulizer kit, unscrewed the mask from the medication reservoir, placed the albuterol/ipratropium solution in the reservoir and reattached the mask. -The mask was placed on Resident #3's face and the nebulizer was turned on. -The albuterol/ipratropium solution aerosolized in the mask which the resident inhaled with no 	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHESTNUT PARK REST HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 64 CHESTNUT PARK DRIVE WAYNESVILLE, NC 28786
---	--

(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
D912	<p>Continued From page 4</p> <p>difficulty.</p> <p>A second interview on 7/20/16 at 4:45PM with Resident #3 revealed: -He had been using the nebulizer kit for "a long time" but could not remember for how long. -He reported the Administrator telling him a couple of times, and most recently that same morning, of a need to change the nebulizer kit. -An outside medical supply company came to the facility about 2 months before to change out the oxygen concentrator and another staff member had changed the oxygen tubing and nasal cannula to the concentrator a month prior. -He thought the nebulizer kit needed to be changed.</p> <p>Interview with the Administrator on 7/20/16 at 5:15PM revealed: -The name of the medical supply company that managed Resident #3's oxygen concentrator (Company A) and another medical supply company that provided nebulizer kits and oxygen supplies (Company B). -The nebulizer kit was last changed out 3 weeks prior but there was no documentation of this and the kit was not labeled with a date. -When the nebulizer kit looked dirty and Resident #3 stated to staff it was not working properly, the nebulizer kit would get changed. -Resident #3 broke a nebulizer kit "the other day" and another staff member had just picked up another one.</p> <p>Telephone interview on 7/21/16 at 9:31AM with Medical Supply Company A revealed: -Their records showed Resident #3 had received a nebulizer from their company in 2014 which the resident now owned. -They serviced oxygen concentrators once a year</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHESTNUT PARK REST HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 64 CHESTNUT PARK DRIVE WAYNESVILLE, NC 28786
---	--

(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
D912	<p>Continued From page 5</p> <p>but did not service nebulizers owned by residents. -They provided nebulizer kits when requested, but there were no purchase records of nebulizer kits for Resident #3 or the facility. -Insurance would reimburse the cost of a disposable nebulizer kit to be changed out once a month.</p> <p>Telephone interview on 7/21/16 at 9:40AM with Medical Supply Company B revealed: -Resident #3's name was not in their records. -Insurance would reimburse the cost of a reusable nebulizer kit, which lasted longer than a disposable nebulizer kit, every 6 months.</p> <p>Telephone interview on 7/21/16 at 9:58AM with the Administrator revealed: -The nebulizer machine used by Resident #3 was once used by a former resident no longer at the facility. -When Resident #3 first arrived at the facility, Home Health brought the facility "some things." -When a family member of the Administrator, who used a nebulizer, died, she had brought his unused respiratory supplies as he had "quite a bit." -The name of the Home Health Nurse who had been working with Resident #3. -There was no written facility policy regarding the changing out of nebulizer kits.</p> <p>Telephone interview on 7/21/16 at 11:01AM with the Home Health Nurse revealed: -Her duties included assessing the respiratory status of Resident #3 and teaching him breathing exercises, but her duties did not include use of his nebulizer. -She had questioned the condition of his oxygen concentrator tubing, which staff changed out, but she had not noticed the condition of his nebulizer</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL044002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER CHESTNUT PARK REST HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 64 CHESTNUT PARK DRIVE WAYNESVILLE, NC 28786
---	--

(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
D912	Continued From page 6 kit.	D912		