

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 and the Wilkes County Department of Social Services conducted a complaint investigation on 06/23/16 through 06/29/16 with an exit conference via telephone on 06/30/16. The complaint investigation was initiated by the Wilkes County Department of Social Services on 06/10/16.	D 000		
D 077	<p>10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times.</p> <p>The findings are:</p> <p>Observation on 06/23/16 at 10:00 am of the posted kitchen health inspection score revealed: -A score of 81, rating of B. -The inspection was completed on 07/24/15.</p>	D 077		

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:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 077	<p>Continued From page 1</p> <p>Observations of the kitchen at various times on 06/23/16 through 06/24/16 and 06/27/16 through 06/29/16 revealed:</p> <ul style="list-style-type: none"> <li>-Spilled red liquid and food debris scattered across the tabletop in food storage area with ants throughout.</li> <li>-Spilled red, sticky, liquid across surface of kitchen manuals.</li> <li>-Popcorn, dried peas, and other food debris in the bottom of storage bins containing lids, pans, condiment containers, and bowls.</li> <li>-Two open, uncovered packages of cookies on the tabletop in the food storage area.</li> <li>-An uncovered bowl of pretzel sticks and open container of sugar on the tabletop in the food storage area.</li> <li>-Personal drink items, including one opened beverage can, on the tabletop in the food storage area.</li> <li>-Ants crawling across the floor, tabletop, and storage shelves in the food storage area.</li> <li>-Dried, red liquid splattered across wall beside the door leading from the kitchen into the dining room.</li> <li>-Underneath a manual can opener mounted on the end of a food prep table, there was dried, dark brown substance on the floor and on the end 5 inches of the lower shelf of the food prep table.</li> <li>-Ants crawling on the floor underneath and around the trashcan to the left side of the door leading into the kitchen from the dining room.</li> </ul> <p>Interview on 06/27/16 at 11:30 am with two cooks revealed:</p> <ul style="list-style-type: none"> <li>-There was a cleaning schedule but they "don't really go by that".</li> <li>-"We just clean whatever we see needs to be cleaned".</li> <li>-They routinely cleaned the kitchen at the end of</li> </ul>	D 077		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 077	<p>Continued From page 2</p> <p>their shift and all throughout their shift as needed.</p> <p>Interview on 06/23/16 at 12:34 pm with the Administrator revealed: -The sanitation score of 81 in the kitchen was a year ago. -The health inspector would not come back until after a year had passed. -She tried to get them to re-inspect, but was told by the inspector's office that the state only required yearly inspections and therefore would not re-inspect until it had been a year (July 2016).</p> <p>Interview on 06/27/16 at 2:00 pm with the Operations Manager (OM) revealed: -He was responsible for the overall operation of the kitchen. -When the facility received the sanitation score of 81 in July 2015, the OM called and requested the inspector return to the facility to re-inspect, but was told he would only inspect once annually. -He knew the sanitation score had to be above 82. -When the overall facility inspection was completed this month, the OM spoke with the inspector and asked him to re-inspect the kitchen. The inspector told the OM he would come back and do it, but would not specify when and had not been back to re-inspect the kitchen. -The low sanitation score in July 2015 was due to the dishwasher not working properly, which had since been fixed, hot water not hot enough, and because the facility had old freezers out back that were not commercial grade. -He was not sure whether or not he received any deficiencies due to cleanliness of the kitchen. -When asked if he was cited due to pest control issues, the OM stated, "They write us up every single time for pest control". -The reason the facility was repeatedly cited for</p>	D 077		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 077	<p>Continued From page 3</p> <p>pest control was because mice droppings were always found in an old building out back, which was "not even attached" to the facility building.</p> <p>-He was not aware of a problem with ants until discussed with surveyor on 06/24/16.</p> <p>-The facility had a contract with a local pest control company which came monthly, but the company had not been to the facility in "a couple of months".</p> <p>-He sprayed over the weekend (06/25/16 through 06/26/16) for ants and put out glue traps.</p> <p>-He has noticed an increase in the pest problem since the exterminator stopped coming.</p> <p>Interview on 06/27/16 at 2:34 pm with a representative from the local pest control company revealed the pest control company used to service the facility monthly, but had not serviced the facility since 11/24/14 due to unpaid bills.</p> <p>Interview on 06/23/16 at 2:45 pm with the health inspector revealed:</p> <p>-He performed the kitchen inspection in July 2015 as well as the overall facility inspection earlier this month.</p> <p>-He did not re-inspect the kitchen this month when he inspected the facility.</p> <p>-He routinely inspected annually unless requested by a facility to return for a re-inspection.</p> <p>-He had received no requests from the facility for a re-inspection of the kitchen and was not asked to re-inspect the kitchen when he conducted the overall facility inspection earlier this month.</p> <p>-If a facility was trying to improve their sanitation score by a few points, he may or may not return to re-inspect upon request, depending on his schedule; however, if a facility requested a re-inspection to improve a letter grade, he would inform them he would return within 15 days to</p>	D 077		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 077	<p>Continued From page 4</p> <p>re-inspect.</p> <p>-In this particular case, if the facility had requested a re-inspection of the kitchen, he would have returned within 15 days of the request to re-inspect.</p> <p>Interview on 06/29/16 at 3:00 pm with the Facility Owner revealed:</p> <p>-She was aware of the kitchen sanitation score of 81.</p> <p>-She thought the score had to be above 80.</p> <p>-She called the inspector's office to request a re-inspection of the kitchen and left a message for them to return her call, but they did not call her back.</p> <p>-She was sure the facility requested a re-inspection of the kitchen earlier in the month when the overall facility inspection was completed because the Administrator called her (Owner) when the inspector left to inform her that he would not re-inspect the kitchen.</p> <p>_____</p> <p>The facility provided a Plan of Protection on 6/29/16 as follows:</p> <p>-The facility will make a formal request in writing to the local health department for a kitchen re-inspection immediately.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2016.</p>	D 077		
D 080	<p>10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall</p>	D 080		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 080	<p>Continued From page 5</p> <p>(6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations and interviews, the facility failed to have a supply of bath soap and washcloths adequate for resident use on hand at all times.</p> <p>The findings are:</p> <p>A. Observations made on 6/29/16 between 2:35 pm and 3:00 pm revealed:</p> <ul style="list-style-type: none"> <li>-In the 500 hall shower room there was no hand soap or shower soap in the dispensers.</li> <li>-In the 600 Hall bath and shower room, there was no hand soap or bath soap and no dispenser for the bath soap.</li> <li>-In the 400 hall shower room, there was no bath soap or hand soap.</li> <li>In the 100 hall shower room, there was no hand soap and the shower soap dispenser was 3/4s full of liquid.</li> <li>-In the Women's 200 shower, there was no shower soap and the two hand soap dispensers contained 1/2" of liquid each.</li> <li>-Both 200 hall Women's bathrooms were locked.</li> <li>-In the 300 hall bathroom/shower, there was a large soap dispenser by the sinks without any soap, an empty soap dispenser by the single sink and a soap dispenser without a cover in the shower which was 1/2 full of a diluted, thin soap mixture.</li> </ul>	D 080		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 080	<p>Continued From page 6</p> <p>Observations made at 4:07 pm in the 200 hall Women's bathroom revealed:</p> <ul style="list-style-type: none"> <li>-One bathroom could be unlocked by an Aide using a credit card and contained no hand soap or bath soap.</li> <li>-The second bathroom on the 200 hall could not be unlocked and the Aide did not have a key.</li> </ul> <p>Interview with the Operations Director on 6/29/16 at 2:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-Housekeepers were responsible for filling up the soap dispensers in all bathroom.</li> <li>-He purchased liquid hand soap and 3 in 1 (soap/shampoo/conditioner) bath soap for the showers.</li> <li>-The Housekeepers store the soap on their carts or in the storage room.</li> <li>-The Housekeepers are supposed to let him know when they are getting low on soap supplies and he would purchase more.</li> </ul> <p>Interview with two of the Housekeepers on 6/29/16 at 2:50 pm revealed:</p> <ul style="list-style-type: none"> <li>-The Housekeepers are responsible for filling the soap dispensers.</li> <li>-There was no soap on the housekeeping carts available to refill the dispensers.</li> <li>-The Housekeepers had told the Operations Director that they needed more soap and shower soap.</li> <li>-The Housekeeper did not remember when she had informed the Operations Director they needed bathing supplies.</li> </ul> <p>Observation of the Housekeeping storage room on 6/29/16 at 2:55 pm revealed:</p> <ul style="list-style-type: none"> <li>-2 bottles of a named brand shampoo and one bottle of generic conditioner.</li> <li>-There was no hand or shower soap available.</li> </ul>	D 080		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 080	<p>Continued From page 7</p> <p>Observation of personal hygiene items stored in the room next to the personal care aide's office on 6/29/16 at 3:00 pm revealed a number of razors, shaving cream, men's and women's deodorants and some tooth paste but no bath or shower soap.</p> <p>Interviews with 3 staff and 5 residents between 2:45 pm and 6:20 pm on 6/29/16 revealed: -There are several days when the soap dispensers are empty. -Two residents said they run out of soap all the time, but eventually the dispensers are filled up. -Two residents stated they have their own soap and shampoo because the facility is always out. -One resident stated they are always out of bath soap; it is a constant problem.</p> <p>Observation of the 500 hall shower/bathroom on 6/29/16 at 6:25 pm revealed: -The hand soap and shower dispensers were full of liquid. -There were 2 empty large bottles of "spa soap" and 1 empty bottle of 3 in 1 soap (men's) in the trash beside the sinks.</p> <p>Interview with the Operations Director on 6/29/16 at 6:30 pm revealed: -He just purchased 11 containers of hand soap and 24 bottles of shower soap. -He had Housekeeping fill up all of the dispensers in the bathrooms so there was soap in all bathrooms.</p> <p>B. Observations on 6/29/16 at 2:00 pm in the laundry room revealed: -A large number of both flat and fitted sheets. -There were 15 folded bath towels on the storage rack and 22 bath towels in the dryers and washers.</p>	D 080		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 080	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-There were no washcloths on the laundry storage shelves.</li> <li>-There were 4 washcloths in the dryers; one washcloth appeared to be a cut up towel with frayed edges.</li> <li>-There were 2 more washcloths found after staff checked all of the resident rooms for a total of 6 available washcloths.</li> </ul> <p>Interview with the Housekeeping Supervisor on 6/29/16 at 2:00 pm revealed:</p> <ul style="list-style-type: none"> <li>-Linens were only stored in the laundry room.</li> <li>-The facility is short on washcloths but the residents like to keep them in their rooms.</li> <li>-She did not know there were so few available for use by residents.</li> <li>-The facility periodically buys extra washcloths when needed, but not recently.</li> </ul> <p>Interviews with 3 staff and 5 residents on 6/29/16 at various times revealed:</p> <ul style="list-style-type: none"> <li>-Two residents reported they frequently did not have towels and washcloths for bathing.</li> <li>-Two staff reported frequently having to wait for laundry in order to have washcloths for bathing.</li> <li>-Two staff reported they would cut up towels in order to make washcloths for bathing some times.</li> <li>-Two residents said they had their own linens and used them for bathing.</li> <li>-The two residents would wash their own towels or let the staff launder them with their personal laundry.</li> </ul> <p>Interview with the Administrator on 6/29/16 at 6:30 pm revealed:</p> <ul style="list-style-type: none"> <li>-She relied on the Operations Manager to monitor Housekeeping and Food supplies.</li> <li>-She was not aware if there were any new/unused washcloths available in the facility.</li> </ul>	D 080		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 080	<p>Continued From page 9</p> <p>-Staff had not made her aware of any shortages.</p> <p>Interview with the Operations Manager on 6/29/19 at 6:35 pm revealed:</p> <p>-Staff had just informed him this afternoon they were short on washcloths.</p> <p>-He believed the residents hoard them in their rooms.</p> <p>-He did purchase 72 washcloths an hour ago and gave them to the Staff for storage and use.</p> <p>_____</p> <p>The facility provided a Plan of Protection on 6/29/16 at 6:45 pm as follows:</p> <p>-The facility will immediately purchase body wash and soap and a supply of washcloths.</p> <p>-The Operations Director will create an inventory sheet the Housekeepers will check twice a week.</p> <p>-The Housekeepers will let the Operations Director know when stock gets low.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 14, 2016.</p>	D 080		
D 188	<p>10A NCAC 13F .0604(e) Personal Care And Other Staffing</p> <p>10A NCAC 13F .0604 Personal Care And Other Staffing</p> <p>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.</p> <p>(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 188	<p>Continued From page 10</p> <p>(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)</p> <p>(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.</p> <p>(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure staffing met minimal requirements according to census for 6 of 15 third shifts between 6/9/16 and 6/23/16 where there were only one personal care aide and one supervisor scheduled to work.</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 188	<p>Continued From page 11</p> <p>The findings are:</p> <p>Review of the facility midnight census sheet revealed the average daily census for the facility from 6/9/16 through 6/23/16 was 50 to 51 residents.</p> <p>Based on the census for this facility, there should be 16 hours of personal care aide and a supervisor on site or within in 500 feet and available at all times.</p> <p>This building is not sprinkled.</p> <p>Observations made in the facility at 6:42 am on 6/24/16 revealed:</p> <ul style="list-style-type: none"> <li>-There was one PCA and one MA at work.</li> <li>-There were a number of residents dressed and up in the halls or sitting in the dining room.</li> </ul> <p>Interview with the Medication Aide on 6/24/16 at 6.42 am revealed:</p> <ul style="list-style-type: none"> <li>-She was the Supervisor for the shift and every shift she worked.</li> <li>-She was responsible for administering medications, resident care and supervision of personal care aides (PCA).</li> <li>-For the last several weeks, there has only been one PCA during the third shift and herself.</li> <li>-There was no staff who lived within 500 ft. of the building.</li> </ul> <p>Interview with staff working at 6:45 am on 6/24/16 revealed:</p> <ul style="list-style-type: none"> <li>-They were the only two staff scheduled to work.</li> <li>-They were the only two staff who did work the third shift beginning on 6/23/16 at 11:00 pm.</li> <li>-No other staff worked any part of the shift, nor had there been any administrative staff in the</li> </ul>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 188	<p>Continued From page 12</p> <p>building that they knew about. -For the third shifts they had worked lately, only one PCA and one MA were scheduled and worked for the entire shift.</p> <p>Observation and review of the staff time punches for the period of 6/9/16 through 6/23/16 for the third shift revealed: -On 6/12, 6/14, 6/16, 6/17, 6/21 and 6/23/16 there were two staff, one Personal Care Aide (PCA) and one Medication Aide (MA), who entered time for those days. -On the other days (6/9, 6/10, 6/11, 6/13, 6/15, 6/18, 6/19, 6/20 and 6/22/16 there were three staff, two PCAs and one MA, who entered time for those days.</p> <p>Review of the facility's clinical schedule for these dates revealed there was only one PCA and one MA were scheduled to work for 12 of the 15 days.</p> <p>Interview with the Business Office Manager (BOM) on 6/23/16 at 12:10 pm revealed: -The clinical staff schedule was completed by the Administrator at least every two weeks. -The BOM checks for time discrepancies at least twice weekly and corrected as needed. -When the pay period time was completed, she sent the time to the Administrator for approval, who in turn sent it to the Owner/Licensee for processing. -Any discrepancies or changes in the recent pay period have already been corrected in the system by the time the pay period ends.</p> <p>Observation made in the facility at 5:30 am on 6/28/16 revealed there was one PCA and one MA working.</p> <p>Interview with the staff on 6/28/16 at 5:45 pm</p>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 188	<p>Continued From page 13</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-There was only one PCA and one MA onsite and working for the third shift beginning on 6/27/16 at 11:00 pm.</li> <li>-Staff responsibilities during their shift beside personal care and supervision included mopping hallways and dining room floors, disposing of trash in bathrooms and laundry.</li> <li>-The staff reported drying and folding 3-4 loads of laundry this shift.</li> <li>-There had been no other management in the building this shift.</li> </ul> <p>Interview with 3 residents up and walking in the facility on 6/28/16 at 6:50 am revealed:</p> <ul style="list-style-type: none"> <li>-There have been only two staff usually on third shift for the last few weeks.</li> <li>-There used to be 3 staff, but not any more.</li> <li>-They always received assistance if they needed it.</li> </ul> <p>Interview with the Administrator on 6/28/16 at 4:30 pm revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for the clinical staffing in the facility.</li> <li>-She was aware that some shifts were short staff.</li> <li>-She came in the building and stayed in her office late in the evenings frequently.</li> <li>-They have had a lot of staff turnover and was struggling to keep up.</li> <li>-She usually told staff when she was in the building but did not enter time or put herself on the schedule.</li> <li>-She did not keep a record of the times she entered late in the evening and could not recall the date of the last late night entry.</li> </ul> <p>Interview with the Owner/Licensee on 6/29/16 at 10:15 am revealed:</p> <ul style="list-style-type: none"> <li>-She was aware the third shift was short staff</li> </ul>	D 188		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 188	Continued From page 14  occasionally. -She thought the Administrator came in at night and slept in her office in the recliner. -She did not have a record of the times the Administrator came in late at night.	D 188		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service  10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets.  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure there was a three-day supply of perishable food and a five day supply of non-perishable food in the facility.  The findings are:  Interview with Administrator on 4/27/16 at revealed: -"We haven't run out of a meal or a snack." -They did not get Friday's 4/22/16 food delivery because Kitchen Staff E, a former disgruntled employee, had cancelled the food truck order on Tuesday, 04/19/16. -The Wi-Fi was not working and another food order could not be placed at that time. -The fax number had been changed, she said she tried to call the food representative on Thursday, 4/21/16, and called the food representative again in the morning on Friday, 4/22/16.	D 285		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 285	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>-They had enough groceries to get to Tuesday morning, 4/19/16.</li> <li>-Kitchen Staff E went through the facility telling people we don' t have food.</li> <li>-The Operations Manager had purchased 25 pizzas at an area restaurant. There were 5 left in the oven. The residents were allowed to have three pieces of pizza.</li> <li>-The Operations Manager was going to the grocery store and buying enough groceries to last until Monday (May 2, 2016).</li> <li>-The Owner said to get enough food until a food truck arrives.</li> <li>-The facility had secured a food vendor.</li> </ul> <p>Observations of meals served on 4/26/16 revealed:</p> <ul style="list-style-type: none"> <li>-Residents were served pancakes, sausage, and eggs for breakfast, pizza and soft drinks for lunch, and chicken and dumplings for supper.</li> </ul> <p>Observation of afternoon snack on 4/27/16 at 3:10pm revealed res-Snack on 4/27/16 a slice of pizza (cut into two pieces) and a choice of a 12 oz. can of diet or regular cola.</p> <p>Observation of the food served for lunch on 4/29/16 revealed stewed chicken over a biscuit, mixed peas and carrots, mashed potatoes, red gelatin and tea was served.</p> <p>Interview with Kitchen Staff A on 5/3/16 revealed:</p> <ul style="list-style-type: none"> <li>-There is always enough food to cook a meal for the residents.</li> <li>-If there is not enough food, they will go to Operations Manager.</li> <li>-If there was not enough food staff would "assess the situation with Operations Manager" and if necessary the Operations Manager would go to the grocery store.</li> <li>-If more food is needed it would be reported to</li> </ul>	D 285		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 285	<p>Continued From page 16</p> <p>Operations Manager.</p> <ul style="list-style-type: none"> <li>-The Operations Manager is always ready to help.</li> <li>-Meals cooked are always cooked according to the menu and if a substitution is needed a paper is filled out.</li> <li>-Food deliveries arrive on Thursday and Friday.</li> </ul> <p>Interview with Kitchen Staff B on 5/3/16 revealed:</p> <ul style="list-style-type: none"> <li>-There is enough food for a meal "most of the time."</li> <li>-If food is needed the Operations Manager or Business Office Manager are informed and they always go (to the store).</li> <li>-The menus are followed "most of the time."</li> <li>-A substitution log is kept.</li> <li>-The food delivery has been switched and they are getting a new one.</li> </ul> <p>Interview with a resident on 5/3/2016 4:00pm revealed:</p> <ul style="list-style-type: none"> <li>-There is enough food.</li> <li>-Milk is provided at breakfast.</li> <li>-Snacks are provided three times a day.</li> </ul> <p>Interview with a resident on 5/3/16 at 4:10pm revealed:</p> <ul style="list-style-type: none"> <li>-The food is "not worth eating."</li> <li>-She does not get enough to eat. and said she does get hungry because she is not getting enough to eat.</li> <li>-Staff "don't write on the menu."</li> <li>-The Kitchen Staff become angry if you ask for more.</li> <li>-She said the Kitchen Staff get mad and don't pay attention and will "slam the door in your face and storm out."</li> <li>-They receive milk for breakfast and on Sunday they were only given water for lunch and dinner.</li> <li>-They do receive snack three times a day, today it was cookies and diet soda.</li> </ul>	D 285		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 285	<p>Continued From page 17</p> <p>Interview with a resident on 5/3/16 at 4:20pm revealed: -She does get enough to eat but does get hungry. -Snacks are given three times a day, sometimes it is "chips and soda." -The menu is not written on the board. -Milk is served at breakfast. -She would not talk to the cook about her concerns, but would not say why. -She would like soy milk and more complex proteins.</p> <p>Interview with a resident on 5/3/16 at 4:30pm revealed: -She does get enough to eat. -She may get second helpings "every blue moon." -She said she would not ask for second helpings. -A menu is on the board "If they put it on there at all." -Three snacks a day are received. -Milk was only served at breakfast.</p> <p>Interview with a resident on 5/3/16 at 5:10pm. -He does eat but sometimes goes without because there is not enough food. -"Sometimes we get seconds." -Supplemental shakes are provided to him with breakfast and supper; however, the staff today gave him crackers instead of his supplemental shake. -Snacks are provided three times a day. -"Sometimes I complain if it's important to me."</p> <p>Confidential interviews with 11 residents revealed: -Five of 11 residents reported being hungry and not receiving enough food. -One resident stated, "I'm starving now! There's not enough food." -One resident stated sometimes he got enough</p>	D 285		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 285	<p>Continued From page 18</p> <p>food, but sometimes he was still hungry. If he asked for seconds, sometimes he would receive seconds and sometimes he did not because there was not enough food.</p> <p>-For supper last night (06/27/16), residents were served "a little bowl of soup and 5 crackers" but it was "better than nothing".</p> <p>-The facility served good food, they "just need more of it".</p> <p>-When asked if ever left the dining room still hungry, one resident stated, "not only sometimes, but every time. Go in hungry, come out hungry".</p> <p>-Two mornings ago, residents were served a "little piece" of sausage, the top half of a hamburger bun, and some applesauce".</p> <p>-Often when requesting a sandwich, residents are told the facility is out of bread and won't have any more until Friday.</p> <p>-One resident stated he did not get enough to eat. The residents used to be able to get seconds, but not for the past couple of months. "They (the facility) just don't have it".</p> <p>-Two residents reported seeing food being thrown away, asking for the food, and being told no because "if one gets seconds, everybody will want them, so no seconds".</p> <p>-One resident stated, "They throw it out and won't let anyone have it! That's terrible when we're coming out of here hungry."</p> <p>-One resident reported for supper last night (06/28/16), residents were served a grilled cheese sandwich, 6 tater tots, and soup, but the soup was not good and she could not eat it. There was okra, corn, and other vegetables in the soup, but she never saw soup like that before.</p> <p>Interview with the Operations Manager on 6/22/16 at 2:20pm revealed:</p> <p>-The walk-in refrigerator has not been working since Friday, June 17, 2016.</p>	D 285		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 285	<p>Continued From page 19</p> <p>-A call had been made to a maintenance company for repair.</p> <p>-The kitchen refrigerator is stocked full "but a lot of it could not fit in there."</p> <p>Review of the facility census on 06/22/16 revealed the current census was 51 residents.</p> <p>Observation on 06/22/16 at 2:30 pm of the posted menus revealed:</p> <p>-There were no breakfast menus.</p> <p>-Lunch and supper menus did not include serving sizes, bread, or beverages.</p> <p>-There were no therapeutic menus.</p> <p>Observation of the food supply on 6/22/16 at 2:30pm revealed the following food supplies available:</p> <p>27 - 15oz. cans of sweet peas 6 - 10.75oz cans of tomato soup 48 - 14.4oz. cans of sauerkraut 24 - 14.5oz. cans of sliced carrots 7 - 15oz. cans of tropical fruit salad 6 - 1lb 10oz. cans of pumpkin 12 - 15.5oz cans of kidney beans 9 - 40oz jars of peanut butter 2 - 13oz. boxes of instant mashed potatoes 3 - 1 lb. boxes of lasagna 19 - 10.5oz cans of chicken noodle soup 12 - 32oz jars of grape jelly 2 - 42oz container of oats 2 - 5lb bag of cornmeal 10 loaves of bread 6 bags of pretzels 6 bags of buttered popcorn 6 packs of cookies 12 gallons of milk 6 dozen eggs 23 slices of cheese 1 stick of butter</p>	D 285		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 285	<p>Continued From page 20</p> <p>3lbs of liver mush 1 bag of approximately 40lbs of chicken 2 - frozen 10lb beef roasts 3 - frozen 5lb to 10lb packages of ground beef 3 - frozen 40lb boxes of chicken thighs and drum sticks</p> <p>Interview with the Kitchen Staff C on 6/22/16 at 2:25pm revealed: -Breakfast served on 6/22/16 consisted of orange juice, milk, eggs, oatmeal, and toast. -Lunch served on 6/22/16 consisted of a soup of beef, peas, and green beans. Collard greens were served. -Dinner menu will be baked chicken, sauerkraut, peas and carrots and fruit, tea, and water.</p> <p>Observation of menu posted on 6/22/16 at 2:40pm revealed: -The lunch menu was Salisbury steak, mashed potatoes, and oriental blend. -The supper menu was hamburger patty, macaroni salad and carrots. There had been no substitutions documented since 5/27/16.</p>	D 285		
D 290	<p>10A NCAC 13F .0904(c)(1) Nutrition And Food Service</p> <p>10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements in Paragraph (d) of this Rule.</p> <p>This Rule is not met as evidenced by:</p>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 21</p> <p>TYPE B VIOLATION</p> <p>The findings are:</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure menus were prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements, resulting in insufficient food preparation.</p> <p>Observation on 06/23/16 at 10:00 am of the posted menus revealed:</p> <ul style="list-style-type: none"> <li>-There were four sheets of paper posted on the kitchen bulletin board, each entitled, "Spring-Summer Cycle Meal Alternates".</li> <li>-The four sheets were labeled Week I, Week II, Week III, and Week IV.</li> <li>-There was no breakfast menu included on any of the sheets.</li> <li>-The menus did not include serving quantities, beverages, desserts, or bread.</li> <li>-Examples of meal plans for this week included: <ul style="list-style-type: none"> <li>-Veal parmesan, mixed vegetables.</li> <li>-BBQ pork on bun, chicken noodle soup.</li> <li>-Salisbury steak, mashed potato, Oriental blend.</li> <li>-Baked chicken, baked potato/broccoli, sour cream.</li> </ul> </li> <li>-The lunch menu for 06/23/16 called for ham, scalloped potatoes, corn.</li> </ul> <p>Interview on 06/23/16 at 12:08 pm with a cook revealed for the lunch menu, he planned to prepare "meat and noodles, some type of gravy, peas and carrots, and some type of bread".</p> <p>Observation on 06/23/16 at 1:00 pm of the lunch meal revealed all residents were served 6 ounces of a mixture of lasagna noodles and spaghetti noodles with ground beef in a red sauce, 4</p>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 22</p> <p>ounces of peas and carrots, 1 slice white bread, 8 ounces water, and 8 ounces sweet tea.</p> <p>Review of the lunch menu for 06/24/16 revealed it called for cube steaks, mashed potato, french green beans.</p> <p>Observation on 06/24/16 at 12:15 pm revealed all residents were served a fried hamburger patty (approximately 4 ounces) with approximately 1 tablespoon of thin, brown, liquid, 4 ounces macaroni and cheese, 4 ounces carrots, 1 slice bread, and 1 pudding snack pack.</p> <p>Interview on 06/24/16 at 8:50 am with a cook revealed: -The four posted sheets on the bulletin board were the facility menus. -He tried to follow the menu as closely as he could. -If he did not have an item listed on the menu, he tried to serve a protein, a starch, a vegetable, and a dessert. -When he was the cook on duty, he decided what food items to prepare and tried to "mix it up" so the residents would not be served the same thing every day. -He routinely served a meat entree, 3 ounces of a starch, 4 ounces of a vegetable. -He had never seen any menus that directed portion sizes.</p> <p>Interview on 06/27/16 at 11:00 am with the Administrator revealed: -She was aware the menus posted in the kitchen did not meet regulatory standards. -She "let the Owner know" about the menus but did not know the exact date she discussed the menus with the Owner. -There was a "menu book" in the kitchen with</p>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 23</p> <p>appropriate menus for Winter and Fall, but there were no appropriate Summer menus. -She did not know where the posted menus came from. -The Operations Manager (OM) was in charge of the kitchen and he "already knows" the menus are not acceptable. -The Facility Owner had to approve changes.</p> <p>Interview on 06/27/16 at 2:00 pm with the Operations Manager revealed: -He was responsible for the overall operation of the kitchen. -He used to purchase food from a large vendor, which had their own menus, but had not used the menus in "about a month" because the facility was no longer purchasing food from that vendor. -He was not able to use the vendor's menus because he would have to purchase the menu items from the vendor, and the facility was no longer using that vendor, and had not contracted with another vendor. -When this facility stopped using the vendor, he asked the Administrator from a sister facility to send him a copy of the menus being used at the sister facility, and the four posted sheets was what the other Administrator sent and said were being used in the sister facility. -The OM spoke with the owner about the need for appropriate menus and the owner said she was "working on them". -For breakfast, the OM had "just been going by (his) experience in the kitchen and (his) memory of previous menus." -The OM had been working in and out of a kitchen for about 8 years.</p> <p>Telephone interview on 06/27/16 at 3:30 pm with a representative from the facility's former food vendor company revealed:</p>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>-The company no longer provided food delivery services for the facility.</li> <li>-The representative stated she was not sure the exact date of the end of service to the facility, but knew the company was "completely out" of business relations with the facility by 05/01/16.</li> <li>-The representative stated she could neither confirm nor deny that nonpayment was the reason for the termination of business relations with the company and could not speak about that "due to current litigation regarding payment".</li> </ul> <p>Interview on 06/29/16 at 3:00 pm with the Owner revealed:</p> <ul style="list-style-type: none"> <li>-She did not know the kitchen staff were using the four posted sheets for a menu to serve the residents.</li> <li>-The Owner sent "actual menus" to the facility (unsure when) electronically so the staff would always have them available.</li> <li>-Maybe the staff did not laminate the menus and put them into use.</li> <li>-The Owner sent the menus again sometime within the past 7-10 days when she became aware there was a problem with the menus.</li> <li>-If the facility staff had informed her earlier there was a problem with the menus, she would have told them the menus were available in the computer system.</li> <li>-She did not know the facility was not using the appropriate menus that were sent to them.</li> <li>-The facility no longer used the previous vendor because it was "cheaper to do it the way we're doing it", the residents get more food, and the facility was able to support the community by purchasing the food locally.</li> <li>-Residents were supposed to be served 3-4 ounces of meat, 6 ounces of starch and 6 ounces of vegetables, which was more than the regulations required.</li> </ul>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>-The OM routinely spent between \$1500 and \$1800 per week on food, which averaged out to \$4.40 per day per resident, which was "in line" with what the facility had been spending when purchasing from the vendor.</li> <li>-Regulations did not require the facility to serve seconds, but the Owner expected the facility to have additional items to supplement if the residents were still hungry.</li> <li>-The facility routinely served more food to the residents than was required in the regulations.</li> <li>-About 2 or 3 weeks ago, the Owner asked the Administrator if there had been any resident weight loss greater than 10% over the past 3-4 months, and was told no.</li> </ul> <p>Review of weight records beginning at various times from 04/06/16 and compared to weights obtained on 06/28/16 for 18 of 52 residents revealed:</p> <ul style="list-style-type: none"> <li>-Residents with overall weight loss of 15 pounds, 14 pounds, 13 pounds, 12 pounds, 11 pounds, three residents at 8 pounds, two residents at 7 pounds, three residents at 6 pounds loss, 4 pounds, and 1 pound.</li> <li>-Three of the 18 residents had documented weight gain of 8 pounds, 6 pounds, and 3 pounds.</li> </ul> <p>Confidential interviews with 11 residents revealed:</p> <ul style="list-style-type: none"> <li>-Five of 11 residents reported being hungry and not receiving enough food.</li> <li>-One resident stated, "I'm starving now! There's not enough food."</li> <li>-One resident stated sometimes he got enough food, but sometimes he was still hungry. If he asked for seconds, sometimes he would receive seconds and sometimes he did not because there was not enough food.</li> <li>-For supper last night (06/27/16), residents were</li> </ul>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 26</p> <p>served "a little bowl of soup and 5 crackers" but it was "better than nothing".</p> <p>-The facility served good food, they "just need more of it".</p> <p>-When asked if ever left the dining room still hungry, one resident stated, "not only sometimes, but every time. Go in hungry, come out hungry".</p> <p>-Two mornings ago, residents were served a "little piece" of sausage, the top half of a hamburger bun, and some applesauce".</p> <p>-Often when requesting a sandwich, residents are told the facility is out of bread and won't have any more until Friday.</p> <p>-One resident stated he did not get enough to eat. The residents used to be able to get seconds, but not for the past couple of months. "They (the facility) just don't have it".</p> <p>-Two residents reported seeing food being thrown away, asking for the food, and being told no because "if one gets seconds, everybody will want them, so no seconds".</p> <p>-One resident stated, "They throw it out and won't let anyone have it! That's terrible when we're coming out of here hungry."</p> <p>-One resident reported for supper last night (06/28/16), residents were served a grilled cheese sandwich, 6 tater tots, and soup, but the soup was not good and she could not eat it. There was okra, corn, and other vegetables in the soup, but she never saw soup like that before.</p> <p>Confidential interview with a cook revealed:</p> <p>- "We just don't have enough".</p> <p>-While preparing for a recent meal, it was reported to the OM and the Administrator there was not enough food and they said they would go buy some, but they never did.</p> <p>-The cook had to "pull together" whatever could be found on hand in the facility.</p> <p>-The OM said the facility was getting new menus,</p>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 27</p> <p>but they did not have them yet. -If there is not enough food to give seconds to everyone, the cook did not give anyone seconds because "it's just not fair". The cook threw the leftover food away.</p> <p>Confidential interview with a staff member revealed: -Residents had been complaining about not getting enough food to eat for the past month to 6 weeks. -The residents did not complain every day, just at various times. -On occasion, there was enough food for some residents to have seconds on a particular meal item. -When asked what staff do when residents complain they are still hungry after a meal, the staff person stated, "The only thing we can do is wait for the next snack or meal time". -The portions served to the residents varied; sometimes they were the "usual amount, decent", but sometimes the portions were small.</p> <p>Confidential interview with a second staff member revealed: -The residents complained "all the time" about being hungry; there were "daily complaints". -The residents did not used to complain about being hungry when the food truck was delivering the food. -If residents were still hungry after a meal and there was no seconds, "There's nothing I can do".</p> <p>Interview on 06/28/16 at 10:48 am with the Administrator revealed: -She realized "about 2 weeks ago" that no one was monitoring weight loss or gain because of a physician comment regarding weights. -The Administrator asked the Resident Care</p>	D 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 290	<p>Continued From page 28</p> <p>Coordinator (RCC) if she was monitoring the weights and was told the RCC was in the process of putting together a weight book.</p> <p>-The Administrator thought the RCC was going to calculate the weight loss/gain and "get back" with her, but she had not yet done so.</p> <p>-The Administrator had "never" heard residents complain about not getting enough to eat and stated, "we give thirds!" (helpings of food).</p> <p>-Some residents had lost weight due to walking "constantly", one resident lost weight because his family wanted him to lose, and some were losing weight because they were not frequenting the snack machines as often because they did not have the money; the Administrator had "stopped them from borrowing (money) from each other".</p> <p>-The Administrator stated the residents' weight loss was due to individual issues as above and not due to the unavailability of food.</p> <p>_____</p> <p>The facility provided a Plan of Protection on 6/29/16 as follows:</p> <p>-Kitchen staff will start using Dietitian approved menus immediately.</p> <p>-The OM will meet with all kitchen staff and notify them of menu change.</p> <p>-The OM will monitor twice weekly to make sure menus are followed.</p> <p>CORRECTION DATE FOR THE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2016.</p>	D 290		
D 310	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 29</p> <p>served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered by the resident's physician for 3 of 3 sampled residents (Residents #5, #26, and #40) resulting in documented weight loss.</p> <p>The findings are:</p> <p>A. Review of Resident #26's current FL-2 dated 02/06/16 revealed: -Diagnoses included dementia, diabetes type II, and Borderline Personality Disorder. -A physician's order for monthly weights. -The 02/06/16 FL-2 did not include an order for nutritional supplements.</p> <p>Review of Resident #26's record revealed: -A physician's order dated 01/28/16 for sugar-free house supplement shakes three times daily with meals. -There was no physician's order to discontinue the supplements.</p> <p>Review of the Medication Administration Records (MARs) for April 2016, May 2016, and June 2016 revealed the nutritional supplements were not listed on the MAR for administration three times daily as ordered by the physician.</p> <p>Interview on 06/27/16 at 10:28 am with a Medication Aide (MA) revealed she did not provide supplements to Resident #26 because</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 30</p> <p>her supplements had been discontinued.</p> <p>Interview on 06/29/16 at 1:30 pm with Resident #26 revealed: -She used to be on nutritional supplements but did not get them anymore. -She did not know how long it had been since she had the supplements. -She was originally put on the supplements because she was losing weight too fast. -The supplements made her gain weight, so she did not drink them anymore, but she "wouldn't mind having them back now" because she was sometimes hungry and could not get second helpings at meals.</p> <p>Review of Resident #26's documented weights revealed: -On 04/06/16, weight was documented as 215 pounds. -On 04/13/16, weight was documented as 208 pounds. -On 05/11/16, weight was documented as 210 pounds.</p> <p>Observation of weight obtained on 06/28/16 revealed Resident #26 weighed 204 pounds.</p> <p>Refer to interview on 06/27/16 at 10:00 am with a Personal Care Aide (PCA).</p> <p>Refer to interview on 06/27/16 at 10:05 am with a second PCA.</p> <p>Refer to interview on 06/27/16 at 9:50 am with a Medication Aide (MA.)</p> <p>Refer to interview on 06/27/16 at 11:30 am with a cook.</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 31</p> <p>Refer to interview on 06/27/16 at 2:00 pm with the Operations Manager (OM).</p> <p>Refer to telephone interview on 06/27/16 with a representative from the facility's former food vendor company.</p> <p>Refer to interviews on 06/27/16 at 11:00 am and 12:15 pm with the Administrator.</p> <p>B. Review of Resident #5's current FL-2 dated 06/23/16 revealed: -Diagnoses included schizophrenia, unspecified neuro-cognitive disorder, hypertension, and hypokalemia. -A physician's order for nutritional supplements 1 can with meals.</p> <p>Review of Resident #5's record revealed: -A physician's order dated 01/14/16 to provide (brand name) nutritional shakes 1 can with each meal. -A physician's order dated 03/11/16 house supplement shakes three times daily.</p> <p>Review of Resident #5's April 2016 and May 2016 Medication Administration Records (MARs) revealed: -An entry for (name brand) nutritional shakes scheduled daily 8:00 am, 12:00 pm, and 5:00 pm. -The supplements were documented as administered three times daily from 04/01/16 through 05/31/16.</p> <p>Review of Resident #5's June 2016 MAR revealed: -Nutritional supplements were scheduled three times daily from 7:00 am to 9:00 am, 11:00 am to 1:00 pm, and 4:00 pm to 6:00 pm. -The supplements were documented as</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 32</p> <p>administered three times daily from 06/01/16 through 06/28/16.</p> <p>Interview on 06/28/16 at 9:12 am with Resident #5 revealed: -She got enough to eat and was not hungry. -"You know those nutrition drinks? I have to watch them because sometimes I don't get them". -Sometimes she received a supplement once or twice a day a couple times a week and sometimes she did not get any supplements at all. -"They don't feed too good".</p> <p>Review of Resident #5's documented weights revealed: -On 05/10/16, weight was documented as 122 pounds. -On 06/03/16, weight was documented as 113 pounds.</p> <p>Observation of weight obtained on 06/28/16 revealed Resident #5 weighed 114.5 pounds.</p> <p>Interview on 06/28/16 at 10:48 am with the Administrator revealed Resident #5's weight loss was due to her walking "constantly".</p> <p>Refer to interview on 06/27/16 at 10:00 am with a Personal Care Aide (PCA).</p> <p>Refer to interview on 06/27/16 at 10:05 am with a second PCA.</p> <p>Refer to interview on 06/27/16 at 9:50 am with a Medication Aide (MA.)</p> <p>Refer to interview on 06/27/16 at 11:30 am with a cook.</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 33</p> <p>Refer to interview on 06/27/16 at 2:00 pm with the Operations Manager (OM).</p> <p>Refer to telephone interview on 06/27/16 with a representative from the facility's former food vendor company.</p> <p>Refer to interviews on 06/27/16 at 11:00 am and 12:15 pm with the Administrator.</p> <p>C. Review of Resident #40's current FL-2 dated 06/01/16 revealed: -Diagnoses included dementia and schizophrenia. -A physician's order for (brand name) supplemental shakes three times daily.</p> <p>Review of Resident #40's record revealed: -A physician's order dated 01/28/16 for house supplement shakes three times daily. -A physician's order dated 05/04/16 for (brand name) nutritional shakes three times daily with meals.</p> <p>Review of the April 2016 Medication Administration Record (MAR) revealed there was no entry for administration of nutritional supplements.</p> <p>Review of the May 2016 MAR revealed: -A handwritten entry for (brand name) nutritional supplements scheduled for administration at 7:30 am, 12:30 pm, and 5:00 pm. -The shakes were documented as administered three times daily beginning 05/10/16.</p> <p>Review of the June 2016 MAR revealed: -An entry for (brand name) nutritional supplement shakes three times daily with meals and</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 34</p> <p>scheduled at 7:00 am to 9:00 am, 11:00 am to 1:00 pm, and 4:00 pm to 6:00 pm.</p> <p>-The shakes were documented as administered three times daily from 06/01/16 through 06/24/16.</p> <p>Interview on 06/24/16 at 9:30 am with Resident #40 revealed:</p> <p>-He used to get "milkshakes" but had not had any in the last couple of weeks.</p> <p>-He was getting "milkshakes", then was changed to "these", and presented an empty container of a store brand nutritional supplement drink.</p> <p>-He had not received any supplements for a couple of weeks.</p> <p>-"None of us ain't getting them".</p> <p>-He was supposed to have the supplements because he had "problems losing weight.</p> <p>Review of documented weight records for Resident #40 revealed:</p> <p>-On 05/04/16, documented weight was 144 pounds.</p> <p>-On 05/17/16, documented weight was 145 pounds.</p> <p>-On 06/07/16, documented weight was 136 pounds.</p> <p>Observation of weight obtained on 06/28/16 was 138 pounds.</p> <p>Interview on 06/28/16 at 10:48 am with the Administrator revealed:</p> <p>-Resident #40 had lost weight because he "walks constantly".</p> <p>-His constant walking was not new behavior; he had always done it.</p> <p>Refer to interview on 06/27/16 at 10:00 am with a Personal Care Aide (PCA).</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 35</p> <p>Refer to interview on 06/27/16 at 10:05 am with a second PCA.</p> <p>Refer to interview on 06/27/16 at 9:50 am with a Medication Aide (MA.)</p> <p>Refer to interview on 06/27/16 at 11:30 am with a cook.</p> <p>Refer to interview on 06/27/16 at 2:00 pm with the Operations Manager (OM).</p> <p>Refer to telephone interview on 06/27/16 with a representative from the facility's former food vendor company.</p> <p>Refer to interviews on 06/27/16 at 11:00 am and 12:15 pm with the Administrator.</p> <p>Interview on 06/27/16 at 10:00 am with a Personal Care Aide (PCA) revealed: -The facility had some nutritional supplements available on occasion and she provided the supplements to the residents when they were available. -She had provided supplements "maybe 5 times" in the past month.</p> <p>Interview on 06/27/16 at 10:05 am with a second PCA revealed she had not seen any nutritional supplements available to give to the residents in "about a month".</p> <p>Interview on 06/27/16 at 9:50 am with a Medication Aide (MA) revealed: -The facility used to provide supplements with meals, but no supplements had been purchased for "at least a month". -There had been no supplements available for the residents since the facility stopped purchasing the</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 36</p> <p>food from the vendor.</p> <p>Interview on 06/27/16 at 11:30 am with a cook revealed: -The facility was getting nutritional supplements from the food vendor, but since the facility had been purchasing its own food, there had only been supplements available "on occasion". -There were supplements available on 06/24/16, but there were none now. -The Operations Manager was "gone to buy some now". -The PCAs request the supplements during meal times and if they were available, the kitchen staff provided them, but they "haven't had any".</p> <p>Interview on 06/27/16 at 2:00 pm with the Operations Manager (OM) revealed: -Nutritional supplements were last purchased from the food vendor, but he would have to check the invoice date to know exactly when they were purchased. -He purchased the supplements in bulk and froze them, but the cooler stopped working on 06/17/16, so they lost their supply. -The facility had been without supplements for "about a week". -The facility was now purchasing "knock-off" nutritional drinks from the store. -The physician orders just say house supplement; he was not aware of any specified brand.</p> <p>Telephone interview on 06/27/16 with a representative from the facility's former food vendor company revealed: -The company no longer provided food delivery services for the facility. -The last nutritional supplements delivered to the facility was a case of 50 supplements on 04/15/16, which she though was the last delivery</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	<p>Continued From page 37</p> <p>made to the facility.</p> <p>-The representative stated she was not sure the exact date of the end of service to the facility, but knew the company was "completely out" of business relations with the facility by 05/01/16.</p> <p>-The representative stated she could neither confirm nor deny that nonpayment was the reason for the termination of business relations with the company and could not speak about that "due to current litigation regarding payment".</p> <p>Interview on 06/27/16 at 11:00 am with the Administrator revealed:</p> <p>-The Operations Manager (OM) was purchasing 4 cases of nutritional supplements (24 cans per case) every Friday.</p> <p>-The facility currently had 8 residents on nutritional supplements.</p> <p>-She saw nutritional supplements on 06/24/16 and was told by the OM that he had purchased two cases.</p> <p>-She kept all food purchase receipts and would provide receipts showing purchases of nutritional supplements from 05/01/16 through 06/24/16.</p> <p>Subsequent interview on 06/27/16 at 12:15 pm with the Administrator revealed:</p> <p>-She reviewed all food purchase receipts for the past month and did not find any purchases of nutritional supplements.</p> <p>-She was not aware the supplements were not being purchased and provided to the residents as ordered by the physician.</p> <p>_____</p> <p>The facility provided a Plan of Protection on 6/29/16 as follows:</p> <p>-The OM will meet with the RCC to ensure all diet orders are up to day and correct.</p> <p>-The OM will meet with kitchen staff to ensure they follow all modified diets and house</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 310	Continued From page 38  supplements diets. -The OM will monitor daily for one wee to ensure diets are followed correctly and then weekly ongoing.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2016.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights  10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.  This Rule is not met as evidenced by: TYPE B VIOLATION  Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents (Resident #53) was free from exploitation as evidenced by a sexual relationship with a staff member (Staff R, Medication Aide).  The findings are:  Review of Resident #53's Resident Register revealed an admission date of 6/26/15 and discharge date of 6/3/16. -At the time of admission, Resident #53 was not her own responsible party and guardianship was through the Department of Social Services in another county. -At the time of discharge, Resident #53 was her own responsible party as of 5/31/16.	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 338	<p>Continued From page 39</p> <p>Review of Resident #53's current FL-2 dated 4/27/16 revealed diagnoses included Schizoaffective disorder bipolar type, strong cluster B personality traits, and polysubstance abuse.</p> <p>Review of a History and Physical dated 06/19/15 revealed: -Resident #53 had been institutionalized since the age of 8 years old. -The resident lost her guardianship approximately 2 years ago.</p> <p>Interview on 06/23/16 at 3:45 pm with Resident #53 revealed: -She moved out of the facility on 05/31/16 after obtaining guardianship rights earlier that day. -She began seeking her guardianship rights, with the assistance of Staff R, around the first week of May 2016. -She had a personal, sexual/romantic relationship with Staff R for about 2 months prior to leaving the facility. -The relationship began prior to her petitioning for guardianship with Staff R's assistance. -The facility Administrator was aware of the romantic/sexual relationship and expressed a desire to attend their wedding. -She informed the Administrator about her relationship with Staff R from the beginning because the Administrator was "my friend" and had planned to become the resident's Power of Attorney, but the paperwork was never filed because the resident got angry and tore up the documents. -On 05/31/16, the resident, Staff R, and the Administrator went out to eat to celebrate the resident's obtaining her guardianship rights. -All facility staff were aware of the romantic/sexual relationship between herself and Staff R.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 338	<p>Continued From page 40</p> <ul style="list-style-type: none"> <li>-Resident #53 and Staff R engaged in sexual relations in the resident's room while Staff R was on duty in the facility.</li> <li>-The resident routinely went home with Staff R when her shift ended at 7:00 am daily and returned with Staff R when she returned to work at 11:00 pm.</li> <li>-The Administrator gave her permission to go home with Staff R; "My guardian never knew."</li> <li>-The romantic/sexual relationship was consensual.</li> <li>-The resident moved out of the facility on 05/31/16 to live with Staff R, but after a couple of weeks, Staff R moved out and left the resident without a place to live.</li> <li>-The resident was currently homeless and did not have access to any of her belongings which were in the trailer she had shared with Staff R.</li> <li>-Staff R is no longer employed at the facility.</li> </ul> <p>Confidential interview with a staff member revealed:</p> <ul style="list-style-type: none"> <li>-The staff member was aware of the romantic relationship between Staff R and Resident #53 and stated, "Everybody knew. "</li> <li>-The staff member reported the Administrator asked various staff members about the relationship between Staff R and the resident "around the first part of May."</li> <li>-Resident #53 wanted to leave the facility and live on her own, but "not quite so soon. (Staff R) was pushing to get their own place."</li> <li>-Resident #53 asked to come back to the facility and had a family member request to allow her to move back in, but the Administrator would not allow her to move back into the facility.</li> </ul> <p>Confidential interview with a second staff member revealed:</p> <ul style="list-style-type: none"> <li>-The staff member was aware of the romantic</li> </ul>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 338	<p>Continued From page 41</p> <p>relationship between Resident #53 and Staff R. -The resident had a previous relationship with another staff member prior to Staff R, who no longer worked at the facility. -The Administrator was aware of both relationships and allowed the resident to leave the facility with the previous employee and her husband. -The staff member heard the Administrator asked every employee here if they had heard any rumors about the resident and Staff R's relationship, but that was not true because the Administrator did not ask this staff member about the relationship.</p> <p>Confidential interview with a third staff member revealed: -The relationship between Resident #53 and Staff R was "never a secret." -The Administrator and other staff had been aware of the relationship since the end of April 2016. -The Administrator was assisting Resident #53 to obtain her guardianship rights "for the sole purpose of allowing (the resident) to move in with (Staff R)".</p> <p>Telephone interview on 06/30/16 at 11:23 am with the Administrator revealed: -She was not aware of a romantic/sexual relationship between Resident #53 and Staff R. -When she confronted the resident and Staff R separately on 05/10/16, they both denied the relationship. -They both denied the relationship under oath at the guardianship hearing. -She questioned the resident and Staff R about the relationship status because she knew about the resident's sexual orientation and that Staff R had offered to allow the resident to move in with</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 338	<p>Continued From page 42</p> <p>her.</p> <p>-When the Administrator confronted Staff R on 05/10/16, she told her, "You know if any of this can be substantiated, I'm going to fire you. That's against policy and it's abuse. "</p> <p>-The Administrator reported she specifically asked Staff R about the rumor of her arriving to work in scrub clothes and later emerging from Resident #53's room wearing the resident's clothing.</p> <p>-The Administrator then stated she did not hear the rumor about the clothing until after Resident #53 had left the facility and she was investigating the rumors. She began investigating because "staff was concerned about how close they were."</p> <p>-The Administrator thought Staff R was helping Resident #53 as a friend and to help her become established in the community.</p> <p>-On the Administrator's first day of employment in the facility in February 2016, she was told about Resident #53's relationship with the previous staff person, but the staff person had already been terminated.</p> <p>-If any staff "knew for sure" about the relationship, they were required to report it.</p> <p>-Resident #53's guardian gave permission to the resident to go out of the facility with Staff R.</p> <p>-The facility had not provided any abuse training for staff since she began working in February 2016; however, the ombudsman had just completed Resident Rights training when she came to work in February.</p> <p>-The Administrator contacted the local health department to come in to talk to residents about safe sex, use of condoms, sexually transmitted diseases because there were 3 or 4 boyfriend/girlfriend resident couples who had expressed concern about the availability of condoms at the facility.</p> <p>-The Administrator stated she did not report the</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 338	<p>Continued From page 43</p> <p>rumor of a relationship to the local Department of Social Services or to the Health Care Personnel Registry.</p> <p>-The Administrator stated she did not consider rumors to be allegations because unless somebody actually sees people having sex, they can't say it has happened.</p> <p>Telephone interview on 06/30/16 at 1:30 pm with Staff R revealed:</p> <p>-She and Resident #53 had a romantic/sexual relationship, but only after the resident was granted her guardianship rights on 05/31/16.</p> <p>-She and Resident #53 did not live together or stay together overnight until after 06/01/16 and were friends until that point.</p> <p>-Staff R assisted the resident to get her guardianship back.</p> <p>-There was an occasion when Staff R wore the residents clothing because Staff R had gotten locked out of her apartment and had to stay with another coworker, so she wore Resident #53's sweat pants when she came in to work that night.</p> <p>-She and Resident #53 lived together for a couple of weeks, but the resident ended the relationship and resumed a previous relationship with another former employee with whom she had been involved before the staff person was terminated .</p> <p>-The former staff person was terminated by the current Administrator for an issue unrelated to the sexual relationship.</p> <p>-The Administrator asked Staff R and Resident #53 if they were having a relationship because someone had reported to the Administrator the two of them were dating, so she wanted to know if it was true.</p> <p>-The Administrator did not provide any instructions to Staff R or Resident #53 about a relationship, but did instruct them they had to be more careful because other residents see them</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 338	Continued From page 44  going out of the facility together and they feel left out. -Staff R expressed concern stating she had been told (unknown source) that she was going to "get in trouble for removing" Resident #53 from the facility.  A Plan of Protection was requested but not received.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2016.	D 338		
D 392	10A NCAC 13F .1008(a) Controlled Substances  10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.  This Rule is not met as evidenced by: TYPE B VIOLATION  Based on observations, interviews, and record reviews, the facility failed to ensure accountability of controlled medications, specifically oxycodone and hydrocodone, for 4 of 5 residents (#17, #36, #38 and #53) sampled who were prescribed hydrocodone or oxycodone.  The findings are:  A. Review of Resident #17's current FL-2 dated 02/05/16 revealed:	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 45</p> <ul style="list-style-type: none"> <li>-The resident's diagnoses included hypothyroidism, hypertension, dementia, major depression disorder, and schizophrenia.</li> <li>-The resident was not noted for orientation.</li> <li>-There was an order for Norco 5/325 (hydrocodone 5mg/acetaminophen 325 mg) at bedtime. (Norco is a controlled substance used to treat pain.)</li> </ul> <p>Review of Resident #17's record revealed:</p> <ul style="list-style-type: none"> <li>-There was a physician's order dated 03/18/16 and 04/20/16 for Norco 5/325 one tablet every night at bedtime and 2 tablets three times a day as needed for breakthrough pain.</li> <li>-There was a physician order dated 05/24/16 for Norco 5/325 three times a day as needed for severe pain.</li> <li>-There was a physician order dated 06/06/16 for Norco 5/325 every 12 hours as needed.</li> <li>-There was a physician's order to discontinue Norco 5/325 mg on 06/18/16.</li> </ul> <p>Telephone interview on 06/24/16 at 4:10 pm with a representative at the contract pharmacy for Resident #17's Norco 5/325 dispensing records revealed:</p> <ul style="list-style-type: none"> <li>-Sixty Norco 5/325 were dispensed on 03/25/16.</li> <li>-Sixty Norco 5/325 were dispensed on 03/29/16.</li> <li>-Sixty Norco 5/325 were dispensed on 04/05/16.</li> <li>-Sixty Norco 5/325 were dispensed on 04/20/16.</li> <li>-Thirty Norco 5/325 were dispensed on 05/02/16, 05/10/16, and 05/24/16.</li> <li>-Six Norco 5/325 were dispensed on 06/06/16.</li> </ul> <p>Review of the controlled substance (CS) logs for Resident #17's Norco 5/325 revealed:</p> <ul style="list-style-type: none"> <li>-There was not a CS log for the 60 tablets of Norco 5/325 dispensed on 03/29/16.</li> <li>-There was not a CS log for the 60 tablets of Norco 5/325 dispensed on 04/20/16.</li> </ul>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 46</p> <p>-There was not a CS log for the 6 tablets of Norco 5/325 dispensed on 06/06/16.</p> <p>-There were CS logs for the dispensings on 03/25/16, 04/05/16, 05/02/16, 05/10/16 and 05/24/16 and documentation of the administration of Norco 5/325 from 04/18/16 through 06/18/16.</p> <p>Review of the March, April, May and June 2016 medication administration records (MARs) for Resident #17 revealed 210 doses of Norco 5/325 tablets were documented as administered as follows:</p> <p>-Nine doses were documented administered for March 2016.</p> <p>-Ninety-two doses were documented administered for April 2016.</p> <p>-Eighty-six doses were documented administered for May 2016.</p> <p>-Twenty-three doses were documented administered in June 2016.</p> <p>Review of medication delivery sheets signed for receipt by a Medication Aide revealed:</p> <p>-Sixty Norco 5/325 were delivered to the facility on 03/30/16, and on 04/21/16.</p> <p>-Six Norco 5/325 were delivered to the facility on 06/07/16.</p> <p>Interview on 6/29/16 at 4:55 pm with Resident #17 revealed:</p> <p>-He received his pain medication routinely at the current time.</p> <p>-His physician had spoken to him about his pain medication being written frequently but the physician wanted him to not run out of medication.</p> <p>-He was not aware of all the dates his physician had prescribed his pain medication.</p> <p>-He stated he thought he should have more pain medication available than the medication aides</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 47</p> <p>said they had on hand for him.</p> <p>Refer to telephone interview on 06/24/16 at 4:10 pm with a representative at the contract pharmacy.</p> <p>Refer to interviews on 06/28/16 at 6:30 am and 4:55 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to telephone interview on 06/28/16 at 4:40 pm with the Director of the contract pharmacy.</p> <p>Refer to interview on 06/27/16 at 9:40 am with the Administrator.</p> <p>Refer to interview on 06/28/16 at 1:30 pm with a representative of the local law enforcement.</p> <p>Refer to telephone interview on 06/29/16 at 3:40 pm with the facility owner.</p> <p>Based on observation of Norco on hand, review of the CS log sheets, and dispensing records and medication administration records, the facility could not account for 126 Norco 5/325 (60 tablets dispensed on 03/29/16, 60 tablets dispensed on 04/20/16, and 6 tablets dispensed on 06/06/16).</p> <p>B. Review of Resident #36's current FL-2 dated 11/23/2015 revealed:</p> <ul style="list-style-type: none"> <li>-The resident's diagnoses included hypertension, mood disorder, coronary artery disease, and schizophrenia.</li> <li>-The resident was not noted for orientation.</li> <li>-There was an order for Norco 10/325 (hydrocodone 10mg/acetaminophen 325 mg) one every 6 hours as needed for pain. (Norco is a controlled substance used to treat pain.)</li> </ul>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 48</p> <p>Review of Resident #36's record revealed:</p> <ul style="list-style-type: none"> <li>-There were subsequent physician's orders dated 03/10/16 ordering Norco 10/325 (hydrocodone 10mg/acetaminophen 325 mg) one every 6 hours as needed for pain.</li> <li>-There was a physician's order dated 03/24/16 ordering Norco 10/325 4 times a day (scheduled).</li> <li>-There was a physician's order dated 04/06/2016 for Norco 10/325 one every 4 hours.</li> </ul> <p>Telephone interview on 06/24/16 at 4:15 pm with a representative at the contract pharmacy for Resident #36's Norco 10/325 dispensing records revealed 480 tablets were dispensed as follows:</p> <ul style="list-style-type: none"> <li>-Ninety (dispensed as a card of 60 tablets plus a card of 30 tablets) Norco 10/325 were dispensed on 04/06/16.</li> <li>-Ninety (dispensed as a card of 60 tablets plus a card of 30 tablets) Norco 10/325 were dispensed on 04/19/16.</li> <li>-Ninety (dispensed as a card of 60 tablets plus a card of 30 tablets) Norco 10/325 tablets were dispensed on 04/29/16.</li> <li>-Thirty Norco 10/325 tablets were dispensed on 05/12/16.</li> <li>-Sixty Norco 10/325 tablets were dispensed on 05/18/16.</li> <li>-Sixty Norco 10/325 tablets were dispensed on 06/02/16.</li> <li>-Sixty Norco 10/325 tablets were dispensed on 06/14/16.</li> </ul> <p>Review of the controlled substance (CS) logs for Resident #36's Norco 10/325 tablets revealed:</p> <ul style="list-style-type: none"> <li>-There was not a CS log for the 30 tablets of Norco 10/325 dispensed on 04/19/16.</li> <li>-Sixty dispensed on 04/06/16 were administered from 04/08/16 to 4/21/16.</li> <li>-Thirty dispensed on 04/06/16 were administered from 06/02/16 to 06/07/16.</li> </ul>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 49</p> <p>-Sixty dispensed on 04/19/16 were administered from 04/21/16 to 05/02/16.</p> <p>-Sixty dispensed on 04/29/16 were administered from 05/02/16 to 05/13/16.</p> <p>-Thirty dispensed on 04/29/16 were administered from 05/13/16 to 05/17/16.</p> <p>-Thirty dispensed on 05/12/16 were administered from 05/18/16 to 05/23/16.</p> <p>-Sixty dispensed on 05/18/16 were administered from 05/23/16 to 06/02/16.</p> <p>-Sixty dispensed on 06/02/16 were administered from 06/07/16 to 06/17/16.</p> <p>-Sixty dispensed on 06/14/16 were administered from 06/17/16 to 06/27/16 (leaving a balance of 3 tablets that matched quantity on hand observed on 06/27/16).</p> <p>Review of the April, May, and June 2016 medication administration records (MARs) and CS log sheets for Resident #36 revealed 210 Norco 10/325 tablets were administered as follows:</p> <p>-There were 109 doses documented as administered from 04/08/16 to 04/30/16.</p> <p>-There were 178 doses documented as administered for May 2016.</p> <p>-There were 156 doses documented as administered from 06/01/16 to 06/27/16 at 2 pm.</p> <p>Review of medication delivery sheets revealed there were 90 tablets of hydrocodone 10mg/acetaminophen 325 mg delivered for Resident #36 on 04/19/16. (Only 60 tablets were documented for administration on CS logs sheet).</p> <p>The CS log sheets or the hydrocodone 10mg/acetaminophen 325 mg tablets were not provided for 30 of the 90 tablets of Norco 10/325 dispensed on 04/19/16 and the facility could not account for the medications.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 50</p> <p>Interview on 06/29/16 at 4:45 pm with Resident #36 revealed: -He was not aware of any time when he needed pain medication but did not have any available for administration. -He did not know how often his pain medication was dispensed and any problem with his pain medication.</p> <p>Refer to telephone interview on 06/24/16 at 4:10 pm with a representative at the contract pharmacy.</p> <p>Refer to interviews on 06/28/16 at 6:30 am and 4:55 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to telephone interview on 06/28/16 at 4:40 pm with the Director of the contract pharmacy.</p> <p>Refer to interview on 06/27/16 at 9:40 am with the Administrator.</p> <p>Refer to interview on 06/28/16 at 1:30 pm with a representative of the local law enforcement.</p> <p>Refer to telephone interview on 06/29/16 at 3:40 pm with the facility owner.</p> <p>Based on observation, record review and interview, the facility could not account for 30 of the 90 tablets of Norco 10/325 dispensed on 04/19/16.</p> <p>C. Review of Resident #38's current FL-2 dated 03/10/16 revealed diagnoses included chronic pain, polysubstance abuse, schizoaffective disorder, and anxiety.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 51</p> <p>Review of Resident # 38's Resident's Register revealed an admission date of 01/07/16.</p> <p>1. Review of Resident #38's current FL-2 dated 03/10/16 revealed an order for Oxycodone 30 mg three times a day. (Oxycodone is a controlled substance used to treat pain.)</p> <p>Review of Resident #38's record revealed a physician's order dated 06/03/16 to discontinue oxycodone 30 mg every 8 hours (3 times a day).</p> <p>Telephone interview on 06/24/16 at 4:30 pm with a representative at the contract pharmacy for Resident #38's oxycodone 30 mg dispensing records revealed 270 tablets were dispensed as follows:</p> <ul style="list-style-type: none"> <li>-Ninety oxycodone 30mg were dispensed on 03/15/16.</li> <li>-Ninety oxycodone 30mg were dispensed on 04/11/16.</li> <li>-Ninety oxycodone 30mg were dispensed on 05/12/16.</li> </ul> <p>Review of the controlled substance (CS) logs for Resident #38's Oxycodone 30 mg revealed:</p> <ul style="list-style-type: none"> <li>-There was not a CS log for 60 tablets of oxycodone 30 mg dispensed on 04/11/16 corresponding to administration from 8:00 am on 04/14/16 to 2:00 pm on 05/02/16 and documented on the resident's Medication Administration Record (MAR) for April and May 2016.</li> <li>-There was not a CS log for 30 tablets of oxycodone 30 mg dispensed on 05/12/16 corresponding to administration from 8:00 am on 06/01/16 to 2:00 pm on 06/03/16 documented on the resident's June 2016 MAR. (Six doses should have been administered leaving 24 tablets).</li> <li>-There were CS logs for the dispensings on</li> </ul>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 52</p> <p>03/15/16, 04/11/16, and 05/12/16, and documentation of the administration of the oxycodone 30 mg from 04/04/16 to 05/31/16.</p> <p>Observation of medication on hand for administration for Resident #38 on 06/24/16 at 5:00 pm revealed no oxycodone 30 mg tablets on hand.</p> <p>Review of the April 2016 Medication Administration Record (MAR) and CS log sheets for Resident #38 revealed: -One hundred-twenty doses of oxycodone 30 mg were documented administered on the MAR. -There was not a CS log for 60 tablets of oxycodone 30 mg dispensed on 04/11/16 corresponding to administration documented on the MAR from 8:00 am on 04/14/16 to 2:00 pm on 05/02/16.</p> <p>Review of the May 2016 MAR and CS log sheets for Resident #38 revealed: -Ninety three doses of oxycodone 30 mg were documented on the MAR administered as scheduled at 6:00 am, 2:00 pm, and 10:00 pm. -There was not a CS log for oxycodone 30 mg corresponding to administration from 8:00 am on 05/01/16 to 2:00 pm on 05/02/16.</p> <p>Review of the June 2016 MAR and CS log sheets for Resident #38 revealed: -There was not a CS log for oxycodone 30 mg corresponding to administration from 8:00 am on 06/01/16 to 2:00 pm on 06/03/16. -Eight doses of oxycodone 30 mg were documented on the MAR for administered as scheduled at 6:00 am, 2:00 pm, and 10:00 pm from 06/01/16 to 06/03/16 with no CS log sheet and no medication on hand for return.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 53</p> <p>Review of medication delivery sheets, signed for by a Medication Aide, for Resident #38 revealed: -There were 90 tablets of oxycodone 30mg delivered for Resident #38 on 04/11/16. -There were 90 tablets of oxycodone 30mg delivered for Resident #38 on 05/13/16.</p> <p>The CS log sheet for 60 tablets of oxycodone 30 mg dispensed on 04/11/16 corresponding to administration documented on the MAR from 8:00 am on 04/14/16 to 2:00 pm on 05/02/16 were not provided.</p> <p>Interview on 06/29/16 at 4:50 pm with Resident #38 revealed: -He was aware he had pain medication that was not available for administration on a few occasions within the last 3 months but did not recall exact dates -He had experienced some shakiness and discomfort when he did not receive his pain medications as scheduled. -He had not required any additional medical treatment as a result of being out of pain medications. -His physician had recently changed his pain medication and he was doing fine.</p> <p>Interview on 06/27/16 at 9:40 am with the Administrator revealed: -She was informed that Resident #38 had controlled medications that were not accounted for beginning in June 2016. -She had investigated the reported discrepancies but had not reported the losses to the pharmacy or local law enforcement.</p> <p>Refer to telephone interview on 06/24/16 at 4:10 pm with a representative at the contract pharmacy.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 54</p> <p>Refer to interviews on 06/28/16 at 6:30 am and 4:55 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to telephone interview on 06/28/16 at 4:40 pm with the Director of the contract pharmacy.</p> <p>Refer to interview on 06/27/16 at 9:40 am with the Administrator.</p> <p>Refer to interview on 06/28/16 at 1:30 pm with a representative of the local law enforcement.</p> <p>Refer to telephone interview on 06/29/16 at 3:40 pm with the facility owner.</p> <p>Based on review of the CS log sheets, and dispensing records and medication administration records, the facility did not have the CS log for 60 tablets of oxycodone 30 mg dispensed on 04/11/16 corresponding to administration from 8:00 am on 04/14/16 to 2:00 pm on 05/02/16 and documented on the resident's Medication Administration Record (MAR) for April and May 2016.</p> <p>Based on observation of oxycodone 30 mg on hand, review of the CS log sheets, and dispensing records and medication administration records, the facility could not account for 30 of the 90 tablets of oxycodone 30 mg dispensed on 05/12/16 and facility did not have CS log sheet for for 60 tablets of oxycodone 30 mg dispensed on 04/11/16.</p> <p>2. Review of Resident #38's current FL-2 dated 03/10/16 revealed an order for Oxycodone 10 mg every 6 hours as needed for pain. (Oxycodone is a controlled substance used to treat pain.)</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 55</p> <p>Review of Resident # 38's record revealed: -There was a physician's order dated 05/27/16 prescribing oxycodone 10 mg 3 times a day for severe pain. -There was a physician's order dated 06/15/16 prescribing oxycodone 10 mg every 6 hours as needed for pain.</p> <p>Telephone interview on 06/24/16 at 4:30 pm with a representative at the contract pharmacy for Resident #38's oxycodone 10 mg dispensing records revealed 210 tablets were dispensed as follows: -Sixty oxycodone 10mg were dispensed on 05/09/16. -Ninety oxycodone 10mg were dispensed on 05/27/16. -Thirty oxycodone 10mg were dispensed on 06/15//16. -Thirty oxycodone 10mg were dispensed on 06/23/16.</p> <p>Review of the controlled substance (CS) logs for Resident #38's Oxycodone 10 mg revealed: -There was not a CS log for 30 of 90 tablets of oxycodone 10 mg dispensed on 05/27/16. -There was not a CS log for 30 tablets of oxycodone 10 mg dispensed on 06/15/16. -There were CS logs for the dispensing on 05/09/16, 05/27/16, and 06/23/16 and documentation of the administration of oxycodone 10 mg from 05/12/16 to 06/27/16 leaving a balance of 22 tablets (observed on hand on 06/27/16)..</p> <p>Review of the May 2016 Medication Administration Record (MAR) and CS log sheets for Resident #38 revealed: -Sixty oxycodone 10mg dispensed on 05/09/16</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 56</p> <p>were administered from 2:00 pm on 05/12/16 through 12:00 am on 05/29/16.</p> <p>-Part of sixty oxycodone 10mg dispensed on 05/27/16 were administered from 4:00 am on 05/29/16 through 8:00 pm on 05/31/16 leaving a balance of 47.</p> <p>-There was not a CS log for 30 of 90 tablets of oxycodone 10 mg dispensed on 05/27/16.</p> <p>Review of the June 2016 MAR and CS log sheets for Resident #38 revealed:</p> <p>-There was not a CS log for 30 tablets of oxycodone 10 mg dispensed on 06/15/16.</p> <p>-Seventy nine doses of oxycodone 10mg were administered from 06/01/16 to 06/27/16 leaving a balance of 22 (observed on hand on 06/27/16).</p> <p>The CS log sheets or the oxycodone 10mg were not provided for 30 tablets of oxycodone 10 mg dispensed on 05/27/16 and 30 tablets dispensed on 06/15/16. The facility could not account for the medication.</p> <p>Interview on 06/29/16 at 4:50 pm with Resident #38 revealed:</p> <p>-He was aware he had pain medication that was not available for administration on a few occasions within the last 3 months but did not recall exact dates</p> <p>-He had experienced some shakiness and discomfort when he did not receive his pain medications as scheduled.</p> <p>-He had not required any additional medical treatment as a result of being out of pain medications.</p> <p>-His physician had recently changed his pain medication and he was doing fine.</p> <p>Interview on 06/27/16 at 9:40 am with the Administrator revealed:</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 57</p> <p>-She was informed that Resident #38 had controlled medications that were not accounted for beginning in June 2016.</p> <p>-She had investigated the reported discrepancies but had not reported the losses to the pharmacy or local law enforcement.</p> <p>Refer to telephone interview on 06/24/16 at 4:10 pm with a representative at the contract pharmacy.</p> <p>Refer to interviews on 06/28/16 at 6:30 am and 4:55 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to telephone interview on 06/28/16 at 4:40 pm with the Director of the contract pharmacy.</p> <p>Refer to interview on 06/27/16 at 9:40 am with the Administrator.</p> <p>Refer to interview on 06/28/16 at 1:30 pm with a representative of the local law enforcement.</p> <p>Refer to telephone interview on 06/29/16 at 3:40 pm with the facility owner.</p> <p>Based on observation of oxycodone 10 mg on hand, review of the CS log sheets, and dispensing records and medication administration records, the facility could not account for 60 oxycodone 10 mg (30 tablets dispensed on 05/27/16 and 30 tablets dispensed on 06/15/16).</p> <p>D. Review of Resident #53's current FL-2 dated 03/17/16 revealed: -The resident's diagnoses included hypertension, diabetes mellitus-insulin dependant, right rotor cuff injury, and schizophrenia. -The resident was not noted for orientation.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 58</p> <p>-There was an order for Percocet 10/325 (oxycodone 10mg/acetaminophen 325 mg) one every 6 hours as needed for pain. (Percocet is a controlled substance used to treat pain.)</p> <p>Review of Resident #53's record revealed: -The resident was admitted on 03/05/15. -The resident was discharged on 04/30/16. -There was a subsequent physician's order dated 04/08/16 ordering oxycodone 10/325 four times a day, as needed for severe pain.</p> <p>Telephone interview on 06/28/16 at 1:30 pm with a representative at the contract pharmacy for Resident #53's Percocet 10/325 dispensing records revealed 170 tablets were dispensed as follows: -Thirty Percocet 10/325 tablets were dispensed on 04/01/16. -Sixty Percocet 10/325 tablets were dispensed on 04/08/16. -Sixty Percocet 10/325 tablets were dispensed on 04/21/16. -Twenty Percocet 10/325 tablets were dispensed on 04/28/16.</p> <p>Review of the controlled substance (CS) logs for Resident #53's Percocet 10/325 revealed: -There was not a CS log for the 60 tablets of Percocet 10/325 dispensed on 04/21/16. -Ninety tablets were administered from 04/03/16 to 04/26/16. -Seven of twenty tablets dispensed on 04/28/16 were administered from 04/29/16 to 4/30/16 leaving a balance of 13. -There was a Medication Release Form dated 4/30/16 documenting 13 Percocet 10/325 released to the resident.</p> <p>Review of the April 2016 CS log sheets for</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 59</p> <p>Resident #53 revealed 110 tablets of Percocet 10/325 were accounted for but 170 tablets were dispensed by the pharmacy provider.</p> <p>Review of medication delivery sheets revealed there were 60 tablets of Percocet 10/325 delivered and signed for by a medication aide for Resident #53 on 04/22/16.</p> <p>The CS log sheets or the medication were not provided for the 60 tablets Percocet 10/325 dispensed on 04/21/16 and the facility could not account for the medication.</p> <p>Resident #53 was not available for interview.</p> <p>Refer to telephone interview on 06/24/16 at 4:10 pm with a representative at the contract pharmacy.</p> <p>Refer to interviews on 06/28/16 at 6:30 am and 4:55 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to telephone interview on 06/28/16 at 4:40 pm with the Director of the contract pharmacy.</p> <p>Refer to interview on 06/27/16 at 9:40 am with the Administrator.</p> <p>Refer to interview on 06/28/16 at 1:30 pm with a representative of the local law enforcement.</p> <p>Refer to telephone interview on 06/29/16 at 3:40 pm with the facility owner.</p> <p>Based on observation of Percocet 10/325 on hand, review of the CS log sheets, and dispensing records and medication administration records, the facility could not account for the 60</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 60</p> <p>tablets of Percocet 10/325 dispensed on 04/21/16.</p> <p>Telephone interview on 06/24/16 at 4:10 pm with a representative at the contract pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy dispensed all controlled medications in bubble cards and sent a controlled substance (CS) log with each bubble card.</li> <li>-The facility was required to sign for all controlled medications sent to the pharmacy. (Review of the controlled packing slips revealed the Medication Aide on duty signed for the medications.)</li> <li>-The pharmacy had no record for any controlled substances returned to the pharmacy in the last 3 months.</li> </ul> <p>Interviews on 06/28/16 at 6:30 am and 4:55 pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> <li>-She started working at the facility early March 2016.</li> <li>-She had previously worked at the facility but not in a few years.</li> <li>-The RCC is responsible to monitor controlled medications for receipt and administration.</li> <li>-The RCC was responsible to report any discrepancies discovered to the Administrator.</li> <li>-She had not reported any missing controlled medications to the contract pharmacy.</li> <li>-She had been working on auditing resident's controlled drug receipt and documentation of administration.</li> <li>-Prior to June 2016 the overstock for all control medications were kept on the medication carts and no log was kept for receipt of the controlled medications and there was no system in place to quickly identify controlled drug discrepancies.</li> <li>-Overstock of controlled medications are now stored in the medication room.</li> </ul>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 61</p> <p>-The facility had put in place a log for entering receipt of controlled medications and sign out of overstock.</p> <p>-She was not aware of medication shortages that were prior to medications discovered for two residents in early June.</p> <p>Telephone interview on 06/28/16 at 4:40 pm with the Director of the contract pharmacy revealed:</p> <p>-The pharmacy had no record for any controlled substances returned to the pharmacy in the last 3 months.</p> <p>-The pharmacy had no record for notification that the facility was missing controlled medications except for notification on 06/27/16 of controlled substance for one resident.</p> <p>Interview on 06/27/16 at 9:40 am with the Administrator revealed:</p> <p>-The Medication Aides were responsible to count and sign off on inventory for controlled medications after each shift.</p> <p>-The RCC would be responsible for reporting discrepancies in controlled medications counts to the Administrator.</p> <p>-She was not aware of controlled medications for any resident that were missing prior to the medications in June 2016.</p> <p>-The facility had implemented a system for tracking receipt and distribution of controlled medications 06/01/16 in response to medication discrepancies.</p> <p>Interview on 06/28/16 at 1:30 pm with a representative of the local law enforcement revealed the facility had not reported any discrepancies in controlled medications within the last 4 to 6 months.</p> <p>Telephone interview on 06/29/16 at 3:40 pm with</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 392	<p>Continued From page 62</p> <p>the facility Owner/Licensee revealed:</p> <ul style="list-style-type: none"> <li>-She was in contact with the Administrator of the building almost every day.</li> <li>-She was not made aware of any discrepancies for controlled medications for April or May 2016.</li> <li>-She was aware the facility had discrepancies for controlled medications for June 2016.</li> <li>-She stated some Medication Aide staff had been dismissed recently for discrepancies regarding controlled medications.</li> <li>-The facility had recently implemented a better tracking system for monitoring receipt and disposition of controlled medications.</li> <li>-The Resident Care Coordinator and the Administrator were responsible for assuring the facility's compliance with rules and regulations.</li> </ul> <hr/> <p>On 06/29/16 the facility provided a Plan of Protection as follows:</p> <ul style="list-style-type: none"> <li>-Immediately the facility would identify residents on controlled substances (medications).</li> <li>-The facility would establish a system to log controls in and sign out for tracking.</li> <li>-Two staff members with the RCC (Resident Care Coordinator) receivables for all narcotics.</li> </ul> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 14, 2016.</p>	D 392		
D 399	<p>10A NCAC 13F .1008 (h) Controlled Substance</p> <p>10A NCAC 13F .1008 Controlled Substance</p> <p>(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the</p>	D 399		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 399	<p>Continued From page 63</p> <p>pharmacy. There shall be documentation of the contact and action taken.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview, and record review, the facility failed to assure missing controlled substances or suspected drug diversion with Scheduled II medications, was reported to the pharmacy for 4 of 5 residents (#17, #36, #38 and #53) sampled who were prescribed controlled substances, specifically oxycodone and hydrocodone.</p> <p>The findings are:</p> <p>Refer to Tag 392, 10A NCAC 13F .1008(a) Controlled Substances.</p> <p>Interview on 06/27/16 at 9:40 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-The Medication Aides were responsible to count and sign off on inventory for controlled medications after each shift.</li> <li>-The RCC would be responsible for reporting and discrepancies in controlled medications counts to the Administrator.</li> <li>-She was not aware of controlled medications for any resident that were missing prior to the medications in June 2016, except Resident #38.</li> <li>-The facility had implemented a system for tracking receipt and distribution of controlled medications 06/01/16 in response to medication discrepancies.</li> </ul> <p>Interviews on 06/28/16 at 6:30 am and 4:55 pm</p>	D 399		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 399	<p>Continued From page 64</p> <p>with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> <li>-She started working at the facility early March 2016.</li> <li>-She had previously worked at the facility but not in a few years.</li> <li>-The RCC is responsible to monitor controlled medications for receipt and administration.</li> <li>-The RCC was responsible to report any discrepancies discovered to the Administrator.</li> <li>-She had not reported any missing controlled medications to the contract pharmacy.</li> <li>-She had been working on auditing resident's controlled drug receipt and documentation of administration.</li> <li>-Prior to June 2016 the overstock for all control medications were kept on the medication carts and no log was kept for receipt of the controlled medications and there was no system in place to quickly identify controlled drug discrepancies.</li> <li>-Overstock of controlled medications are now stored in the medication room.</li> <li>-The facility had put in place a log for entering receipt of controlled medications and sign out of overstock.</li> <li>-She was not aware of medication shortages that were prior to medications discovered for two residents in early June.</li> </ul> <p>Interview with the Administrator on 6/28/16 at 10:05 am revealed:</p> <ul style="list-style-type: none"> <li>-She became aware the facility was missing a card of Oxycodone 30mg for Resident #38 on 6/1/16.</li> <li>-She became aware the facility was missing a card of thirty oxycodone 10 mg dispensed on 06/15/16 for Resident #38 on 06/16/16.</li> <li>-She reported the drug were missing from 6/1/16 on 6/20/16 to the Sheriff's office.</li> <li>-She had not reported the missing medications to</li> </ul>	D 399		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 399	<p>Continued From page 65</p> <p>the pharmacy.</p> <p>Interview on 6/28/16 at 4:40 pm with the facility's pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-There was no documentation received regarding the suspected drug diversion of 6/1/16 or 6/16/16.</li> <li>-There was no documentation for the reporting of any controlled medications for Resident #17, Resident #36, or Resident #53.</li> </ul> <p>Telephone interview on 06/29/16 at 3:40 pm with the facility Owner/Licensee revealed:</p> <ul style="list-style-type: none"> <li>-She was in contact with the Administrator of the building almost every day.</li> <li>-She was not made aware of any discrepancies for controlled medications for April 2016 or May 2016.</li> <li>-She was aware the facility had discrepancies for controlled medications for June 2016.</li> <li>-She stated some Medication Aide staff had been dismissed recently for discrepancies regarding controlled medications.</li> <li>-The facility had recently implemented a better tracking system for monitoring receipt and disposition of controlled medications.</li> <li>-The Resident Care Coordinator and the Administrator were responsible for assuring the facility's compliance with rules and regulations.</li> </ul> <p>On 06/29/16, the facility provided a Plan of Protection as follows:</p> <ul style="list-style-type: none"> <li>-The Administrator will immediately notify law enforcement, the pharmacy provider, physicians, and local Department of Social Services.</li> <li>-In the absence (of the Administrator), the Operations Director will notify above, if any medication discrepancies for all medications including narcotics.</li> </ul> <p>CORRECTION DATE FOR THE TYPE B</p>	D 399		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 399	Continued From page 66  VIOLATION SHALL NOT EXCEED August 14, 2016.	D 399		
D 422	<p>10A NCAC 13F .1104 (d) Accounting For Resident's Personal Funds</p> <p>10A NCAC 13F .1104 Accounting For Resident's Personal Funds</p> <p>(d) A resident's personal funds shall not be commingled with facility funds. The facility shall not commingle the personal funds of residents in an interest-bearing account.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure resident funds they managed were not commingled with facility funds and readily available for resident needs.</p> <p>The findings are;</p> <p>Interview with the Administrator on 6/23/16 at 12:45 pm revealed: -She did not handle resident funds. -The Business Office Manager (BOM) and the Operations Manager (OM) handled resident funds. -She knew each resident who had monies owed to the pharmacy, had \$15 deducted each month to pay towards the balance of the pharmacy charges. -Some residents give all their money away after they receive it. -Those residents who can manage their money can get all of the funds due.</p>	D 422		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 422	<p>Continued From page 67</p> <p>Interview with the BOM on 6/23/16 at 1:00 pm revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for the disbursement of funds to residents.</li> <li>-She always paid personal funds on the 10th of the month.</li> <li>-She sent the request for resident funds payout to the owner/licensee and the owner/licensee would send the draft/monies to the local bank.</li> <li>-The OM would go to the local bank and pick up the cash for disbursement of resident funds.</li> <li>-There was no separate resident funds trust account at any bank that she was aware of.</li> </ul> <p>Review of the individual resident funds account ledger revealed:</p> <ul style="list-style-type: none"> <li>-A total of \$970 was deducted in April 2016 from 53 residents' funds to be sent to the pharmacy for outstanding balances.</li> <li>-A total of \$720 was deducted in May 2016 from 49 residents' funds to be sent to the pharmacy for outstanding balances</li> <li>-A total of \$901.98 was deducted in June 2016 from 49 residents' funds to be sent to the pharmacy for outstanding balances.</li> </ul> <p>A subsequent interview on 6/24/16 at 10:05am with the BOM revealed:</p> <ul style="list-style-type: none"> <li>-She paid the pharmacy bill via money order.</li> <li>-She sent a money order on May 24, 2016 for March 2016 to apply to the pharmacy bill in amount of 624.40.</li> <li>-She sent a money order on June 14, 2016 for April 2016 to apply to the pharmacy bill in amount of \$641.33.</li> <li>-She would deduct \$15 from each resident to pay for their outstanding pharmacy balances.</li> <li>-She could not explain the difference between the monies deducted from the resident funds for the pharmacy bill and the total amount paid to the</li> </ul>	D 422		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 422	<p>Continued From page 68</p> <p>pharmacy.</p> <p>Review of the BOM's spread sheet reflecting resident funds balance due revealed:</p> <ul style="list-style-type: none"> <li>-There were 21 residents with outstanding resident funds balance according to the facility's ledgers.</li> <li>-The balances in the resident funds accounts range from \$0.59 to \$1201.00.</li> <li>-There were 4 Resident Trust Accounts with a balance of \$463.39, \$807.00, \$1156.67 and \$1201.00.</li> <li>-The total outstanding resident funds due and owing according to the facility's resident funds ledgers was \$5106.70.</li> <li>-There was only \$227 in the resident fund account.</li> </ul> <p>Continued interview with the BOM on 6/29/16 at 11:40 am revealed:</p> <ul style="list-style-type: none"> <li>-The BOM reported she did not manage resident funds for approximately 5 months while she was training and worked in the Resident Care Coordinator position.</li> <li>-She returned to the business office and started maintaining the fund account in mid-December 2015.</li> <li>-The Business Office was broken into in January 2016 and the facility safe was taken.</li> <li>-The BOM kept all cash in the safe and she had been told it was around \$2000.</li> <li>-She now kept the resident funds at home and brought it to the facility when she knew she had a disbursement due.</li> <li>-If residents had an immediate need for cash, she would pay them out of her pocket and then deduct same amount from their account and reimburse her cash outlay from the money kept at her home.</li> <li>-She had never balanced the account and had</li> </ul>	D 422		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 422	<p>Continued From page 69</p> <p>\$227 in cash. -Each month at pay out, the residents sign their ledger page and receive what money is indicated on the page.</p> <p>Interview with the Owner/Licensee on 6/29/16 at 6:15 am revealed: -She received a list of Resident Fund deposits from the BOM. -There was no separate Resident Fund Trust account or other bank account in which resident funds are kept. -She relied on the BOM or OM to send the request of balance payments to close resident funds and thought the balances were kept at zero. -She was not aware of any residents who had balances due.</p> <p>A later interview with the BOM on 6/29/16 at 10:40 am revealed; -She received a list of resident funds deposits from the Owner/Licensee and a check for the amount on the list soon after the 1st of the month. -The OM deposited the check in the local account of the corporation. -The BOM posted the individual amounts to the resident funds ledgers as soon as she received the list. -There is no resident funds bank account in use. -She has never added the outstanding balances from the resident funds account ledger to determine the amount of resident funds in the account.</p> <p>Interview with Resident #47 on 6/24/16 at 12:45pm revealed: -He gets \$51.00 a month. -He said he gets all of his money at one time on the 10th of the month.</p>	D 422		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 422	<p>Continued From page 70</p> <p>-He said his medications are \$15.00 each month. -He said he does not have any concerns with his money and that everyone pays the same amount for meds to be fair.</p> <p>Interview with Resident #14 on 6/24/16 at 1:50pm revealed: -She gets \$51.00 a month. -She said paid on the 10th of the month. -She pays \$15.00 to the pharmacy each month. -She was not sure how much her medications are each month but thought they were \$5.00.</p> <p>Interview with Resident #44 on 6/24/16 at 1:00pm revealed: -He gets \$51.00 a month. -He said he is paid on the 10th of the month.</p> <p>Based on interviews and record reviews, the facility failed to assure an accurate accounting of resident funds and commingled resident funds with corporate funds on a regular basis.</p>	D 422		
D 438	<p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record reviews and interviews, the facility failed to report suspected resident</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 438	<p>Continued From page 71</p> <p>exploitation related to an alleged sexual relationship between a resident and a staff member, and two incidences of suspected drug diversion to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of the events and for failure to complete the 5 day report to the HCPR.</p> <p>The findings are:</p> <p>Interview with the Administrator on 6/28/16 at 10:05 am revealed:</p> <ul style="list-style-type: none"> <li>-She did not file a 24hr/5 day report regarding a suspected drug diversion on 6/1/16 until 6/16/16.</li> <li>-She did not think she had to report to the HCPR because her investigation was not substantiated.</li> <li>-She did not file a 24hr/5 day report regarding a suspected alleged sexual relationship between a resident and staff member on 6/1/16 until 6/16/16 when the county DSS brought it to her attention and her investigation did not substantiate the allegation.</li> <li>-She did not file a 24hr/5 day report regarding suspected drug diversion which occurred on 6/16/16 until 6/27/16 because she was waiting for the pharmacy to get back in touch with her.</li> <li>-She did file a 24 hr report regarding suspected drug diversion on 6/25/16.</li> <li>-She said she was not aware she needed to file a 24hr/5 day HCPR report until informed by the county DSS on 6/16/16.</li> <li>-She stated she conducted her own investigation and unsubstantiated the event regarding the 6/1/16 inappropriate sexual relationship between a staff member and a resident.</li> <li>-She reported the drug diversion of 6/1/16 on 6/20/16 to the Sheriff's office.</li> <li>-She reported she had been an Administrator and consultant since the 1980s and had only filed one previous 24hr/5day report (which was for drug</li> </ul>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 438	<p>Continued From page 72</p> <p>diversion at another facility.)</p> <p>Review of two HCPR 24 hour reports dated 6/16/16 completed by the Administrator and faxed on 6/20/16 to the HCPR revealed:</p> <ul style="list-style-type: none"> <li>-One report alleged resident abuse and neglect on 6/1/16.</li> <li>-The report identified a "reasonable suspicion of a crime."</li> <li>-In the "Allegation Description" section, no incident date or time was entered, and contained the statement "there is suspicion that [staff member's name] was having a sexual relationship with a former resident while the resident was still admitted to the facility."</li> <li>-The report denoted Law Enforcement was notified on 6/16/16 at 4:00 pm with a "reasonable suspicion of a crime" selected.</li> <li>-The other 24hr HCPR report dated 6/16/16 alleged resident abuse, resident neglect, diversion of resident drugs, diversion of facility drugs and fraud against resident with reasonable suspicion of a crime related to these allegations regarding the 6/1/16 incident.</li> </ul> <p>Interview with the Administrator on 6/28/16 at 10:05 revealed:</p> <ul style="list-style-type: none"> <li>-She was aware of the allegation of a sexual relationship between a staff person and a resident in May 2016.</li> <li>-She did not believe the relationship was sexual.</li> <li>-She was aware the staff person named in the report had frequent personal encounters with the resident in the facility and outside of the facility during the month of May 2016.</li> <li>-The facility was missing a card of Oxycodone 30mg (a potent narcotic) discovered on 6/1/16 which was the reason the suspected staff person was drug tested and quit before termination.</li> </ul>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 438	<p>Continued From page 73</p> <p>Review of a HCPR 5 day report dated 6/20/16 referencing the drug diversion of 6/1/16 revealed: -Only the drug diversion was investigated on the report. -There was no HCPR 5 day report documentation of inappropriate relationship between staff and resident, nor any investigation findings.</p> <p>Interview with the HCPR investigator on 6/28/16 at 9:00 am revealed: -The 24hr HCPR reports for the incidents of 6/1/16 were received by fax on 6/20/16. -The 5 day reports for the incidents had not been received as yet. -She had not received any 24hr report regarding drug diversion for 6/16/16 or 6/25/16 as of yet.</p> <p>Review of a 24hr HCPR initial report documenting a suspected drug diversion of 6/16/16 revealed: -The report had been completed by the Administrator. -There was no date of completion nor a fax confirmation attached. -The report documented pill replacement of a resident's Oxycodone 5 mg tablets. -This report was not submitted to the HCPR until 6/27/16. -The allegation section documented "reasonable suspicion of a crime and diversion of resident drugs."</p> <p>There was no 5 day HCPR report of investigation of the 6/16/16 drug diversion available for review.</p> <p>Interview with the Administrator on 6/28/16 at 10:05 am revealed: -She did not complete a 24hr HCPR initial report on 6/17/16 for the 6/17/16 diversion. -She did complete a 24hr HCPR initial report on 6/27/16 for the drug diversion of 6/25/16.</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 438	<p>Continued From page 74</p> <ul style="list-style-type: none"> <li>-She had not completed a 5 Day investigation report for the 6/17/16 drug diversion.</li> <li>-She did not report the suspected drug diversion to local Law Enforcement.</li> <li>-She said she put the card in question into the tote to return to the pharmacy for identification.</li> <li>-She stated she put a sticky note on the card asking help in identifying the medication replaced and put it into the return pharmacy tote.</li> <li>-She did not follow up with the pharmacy.</li> </ul> <p>Interview on 6/28/16 at 4:40 pm with the facility's pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-There was no documentation received regarding the suspected drug diversion of 6/1/16 or 6/16/16.</li> <li>-No pharmacy card with substituted pills was received from the facility by the pharmacy from the tote delivery.</li> </ul> <p>Telephone interview with the HCPR Investigator on 7/8/16 at 11:00 am revealed she had not received the 5 day report for the 6/17/16 or 6/25/16 suspected drug diversion as yet.</p> <p>Interview with the Owner/Licensee on 6/29/16 at 10:15 am revealed:</p> <ul style="list-style-type: none"> <li>-She assumed the Administrator knew about the requirement of notification to the HCPR for the 24hr/5 day report and investigation requirement.</li> <li>-She was aware of the 6/1/16 allegations and the 6/25/16 allegations, but was not aware of the 6/17/16 drug diversion allegation.</li> </ul> <hr/> <p>The facility provided the following Plan of Protection on 6/29/16 as follows:</p> <ul style="list-style-type: none"> <li>-Immediately complete the HCPR 24hr and 5 day working report for the outstanding diversions and sexual relationships.</li> <li>-Incident reports are to be completed if any</li> </ul>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 438	Continued From page 75  resident bruised, allegation of abuse or neglect. -Will contact HCPR for assistance and clarification.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 14, 2016.	D 438		
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 on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding nutrition and food service, controlled substances, housekeeping and furnishings, investigating and reporting to Health Care Personnel Registry, and accounting for residents' personal funds.  The findings are:  A. Based on observations, interviews, and record reviews, the facility failed to ensure menus were prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements, resulting in inadequate food preparation and resident weight	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 76</p> <p>loss. [Refer to Tag 290, 10A NCAC 13F .0904(c) (1) (Type B Violation).]</p> <p>B. Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. [Refer to Tag 077, 10A NCAC 13F .0306(a)(4) (Type B Violation).]</p> <p>C. Based on observations and interviews, the facility failed to have a supply of bath soap and washcloths adequate for resident use on hand at all times. [Refer to Tag 080, 10A NCAC 13F .0306(a)(6) (Type B Violation).]</p> <p>D. Based on observations, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered by the resident's physician for 3 of 3 sampled residents (Residents #5, #26, and #40) resulting in documented weight loss. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) (Type B Violation).]</p> <p>E. Based on record reviews and interviews, the facility failed to report suspected resident exploitation related to an alleged sexual relationship between a resident and a staff member, and two incidences of suspected drug diversion to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of the events and for failure to complete the 5 day report to the HCPR. [Refer to Tag 438, 10A NCAC 13F .0102 (Type B Violation).]</p> <p>F. Based on observations, interviews, and record reviews, the facility failed to ensure accountability of controlled medications, specifically oxycodone and hydrocodone, for 4 of 5 residents ((#17, #36,</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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 77  #38 and #53)) sampled who were prescribed hydrocodone or oxycodone. [Refer to Tag 392, 10A NCAC 13F .1008(a) (Type B Violation).]  G. Based on observation, interview, and record review, the facility failed to assure missing controlled substances or suspected drug diversion with Scheduled II medications, was reported to the pharmacy for 4 of 5 residents (#17, #36, #38 and #53) sampled who were prescribed controlled substances, specifically oxycodone and hydrocodone. [Refer to Tag 399, 10A NCAC 13F .1008(h) (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 observation, interview and record review, the facility failed to ensure residents were free of neglect as evidenced by the failure to ensure substantial non-compliance with rules and regulations related to resident rights, nutrition and food service, controlled substances, resident funds and helath care personnel registry and free of exploitation as evidenced by the continued sexual inappropriate behavior between facility staff and a resident.  The findings are:  1. Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents (Resident #53) was free from exploitation as evidenced by a sexual relationship	D914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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
D914	Continued From page 78  with a staff member (Staff R, Medication Aide). [Refer to Tag 338, 10A NCAC 13F.0909 (Type B Violation).]  2. Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to treat residents with respect, consideration, dignity, the failure to provide appropriate care and services, and the failure to provide the services necessary to maintain the residents' physical and mental health as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes regarding nutrition and food service, controlled substances, housekeeping and furnishings, investigating and reporting to Health Care Personnel Registry, accounting for residents' personal funds and continued sexual inappropriate behavior between facility staff and a resident, which is the responsibility of the administrator. [Refer to Tag 980, 10A NCAC G.S. 131D-25 (Type B Violation).]	D914		
D980	G.S. § 131D-25 Implementation  G.S. 131D-25 Implementation  Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.  This Rule is not met as evidenced by: TYPE B VIOLATION	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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
D980	<p>Continued From page 79</p> <p>Based on observations, interviews and record reviews, the administrator failed to ensure that the management, operations, and policies of the facility ensured implementation of resident rights by the failure to treat residents with respect, consideration, dignity, the failure to provide appropriate care and services, and the failure to provide the services necessary to maintain the residents' physical and mental health as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes regarding nutrition and food service, controlled substances, housekeeping and furnishings, investigating and reporting to Health Care Personnel Registry, accounting for residents' personal funds and continued sexual inappropriate behavior between facility staff and a resident, which is the responsibility of the administrator.</p> <p>The findings are:</p> <p>Interview on 06/27/16 at 11:00 am with the Administrator revealed: -She had been working at the facility since February 2016. -She was not a company employee, but was a consultant. -She had overall responsibility for the day-to-day operations of the facility. -She had no access to any company funds; all purchases had to be approved by the owner and the Operations Manager was the only one with purchasing abilities.</p> <p>Interview on 06/27/16 at 2:00 pm with the Operations Manager revealed: -He had been employed at the facility for 4 years. -He was responsible for the overall operation of the kitchen and "anything non-clinical".</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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
D980	<p>Continued From page 80</p> <p>Interview on 06/29/16 at 3:00 pm with the facility Owner/Licensee revealed: -She was in the facility "at least every month" . -She had given the Administrator all management responsibilities. -She was available to the facility management staff 24 hours a day, 7 days a week and returned calls within 20-30 minutes.</p> <p>Noncompliance identified during the survey included:</p> <p>A. Based on observations, interviews, and record reviews, the facility failed to ensure menus were prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements, resulting in inadequate food preparation and resident weight loss. [Refer to Tag 290, 10A NCAC 13F .0904(c) (1) (Type B Violation).]</p> <p>B. Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. [Refer to Tag 077, 10A NCAC 13F .0306(a)(4) (Type B Violation).]</p> <p>C. Based on observations and interviews, the facility failed to have a supply of bath soap and washcloths adequate for resident use on hand at all times. [Refer to Tag 080, 10A NCAC 13F .0306(a)(6) (Type B Violation).]</p> <p>D. Based on observations, interviews, and record reviews, the facility failed to ensure nutritional supplements were served as ordered by the resident's physician for 3 of 3 sampled residents (Residents #5, #26, and #40) resulting in</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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
D980	<p>Continued From page 81</p> <p>documented weight loss. [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) (Type B Violation).]</p> <p>E. Based on record reviews and interviews, the facility failed to report suspected resident exploitation related to an alleged sexual relationship between a resident and a staff member, and two incidences of suspected drug diversion to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of the events and for failure to complete the 5 day report to the HCPR. [Refer to Tag 438, 10A NCAC 13F .1205) (Type B Violation).]</p> <p>F. Based on observations, interviews, and record reviews, the facility failed to ensure accountability of controlled medications, specifically oxycodone and hydrocodone, for 4 of 5 residents (#17, #36, #38 and #53) sampled who were prescribed hydrocodone or oxycodone. [Refer to Tag 392, 10A NCAC 13F .1008(a) (Type B Violation).]</p> <p>G. Based on observation, interview, and record review, the facility failed to assure missing controlled substances or suspected drug diversion with Scheduled II medications, was reported to the pharmacy for 4 of 5 residents (#17, #36, #38 and #53) sampled who were prescribed controlled substances, specifically oxycodone and hydrocodone. [Refer to Tag 399, 10A NCAC 13F .1008(h) Type B Violation).]</p> <p>H. Based on observations, interviews, and record reviews, the facility failed to assure there was a three-day supply of perishable food and a five day supply of non-perishable food in the facility. [Refer to Tag 285, 10A NCAC 13F .0904(a)(4).]</p> <p>I. Based on observations, interviews and record</p>	D980		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL097014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/30/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WILKES COUNTY ADULT CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>176 REST HOME ROAD WILKESBORO, NC 28697</b>
---	---

(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
D980	<p>Continued From page 82</p> <p>reviews, the facility failed to assure all of the resident funds they managed were not commingled with facility funds and readily available for resident needs. [Refer to Tag 422, 10A NCAC 13F .1104(d).]</p> <p>J. Based on observations, interviews and record reviews, the facility failed to assure 1 of 1 sampled residents (Resident #53) was free from exploitation as evidenced by a sexual relationship with a staff member (Staff R, Medication Aide). [Refer to Tag 338, 10A NCAC 13F. 0909 (Type B Violation).]</p> <p>K. Based on observations, record reviews and interviews, the facility failed to assure staffing met minimal requirements according to census for 6 of 15 third shifts between 6/9/16 and 6/23/16 where there were only one personal care aide and one supervisor scheduled to work. [Refer to Tag 188, 10A CNAC 13F. 0604(e)(1)(C).]</p> <p>_____</p> <p>A Plan of Protection was requested but not received.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 14, 2016.</p>	D980		