

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL008039</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/16/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINSTON GARDENS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>205 WEST WATSON STREET<br/>WINDSOR, NC 27983</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 000                                                      | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | D 000                                                                                        |                                                                                                                          |                                                        |
| D 248                                                      | <p>10A NCAC 13F .0704 (b) Resident Contract, Information On Home And</p> <p>10A NCAC 13F .0704 Resident Contract, Information On Home And Resident Register</p> <p>(b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the information on the form as needed. The Resident Register is available on the internet website, <a href="http://facility-services.state.nc.us/gcpage.htm">http://facility-services.state.nc.us/gcpage.htm</a>, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation, record review and interview, the facility failed to assure a completed and signed Resident Register for 3 of 3 residents admitted in the past 2 months (Residents #1, #2, #3).</p> <p>The findings are:</p> <p>A. Review of Resident #1's record revealed:<br/>-She was admitted to the facility on 11/10/14.<br/>-A Resident Register signed by the resident and facility representative on 11/11/14.</p> | D 248                                                                                        |                                                                                                                          |                                                        |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINSTON GARDENS</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>205 WEST WATSON STREET<br/>WINDSOR, NC 27983</b> |                                                                                                                          |                                                        |
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| D 248                                                      | <p>Continued From page 1</p> <p>-Page 2 and 3 of the Resident Register which includes Personal Information in regards to required assistance, memory status, special aids such as walker, eye glasses, dentures, hearing aid, personal habits, known allergies, food preferences, community involvement, hobbies, activity interests and request for assistance were not filled in.</p> <p>Attempted interview with Resident #1 on 1/16/15 at 11:45 a.m. revealed she did not remember completing a Resident Register.</p> <p>Refer to interview on 1/16/15 at 11:30 a.m. with the Manager.</p> <p>B. Review of Resident #2's record revealed:<br/>-He was admitted to the facility on 12/5/14<br/>-The first page and third page of the Resident Register.<br/>-Pages 2 and 4 of the Resident Register which included Personal Information in regards to required assistance, memory status, special aids such as walker, eye glasses, dentures, hearing aid, personal habits, known allergies, food preferences, community involvement, hobbies, activity interests and signature page were not in the record or on file in the facility.</p> <p>Refer to interview on 1/16/15 at 11:30 a.m. with the Manager.</p> <p>C. Review of Resident #3's record revealed:<br/>-He was admitted to the facility on 11/10/14.<br/>--A Resident Register signed by the resident and facility representative on 11/11/14.<br/>-Page 2 and 3 of the Resident Register which includes Personal Information in regards to required assistance, memory status, special aids such as walker, eye glasses, dentures, hearing</p> | D 248                                                                                        |                                                                                                                          |                                                        |

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| D 248                                                      | Continued From page 2<br><br>aid, personal habits, known allergies, food preferences, community involvement, hobbies, activity interests and request for assistance were not filled in.<br><br>Refer to interview on 1/16/15 at 11:30 a.m. with the Manager.<br><br>_____<br><br>Interview with the Manager on 1/16/15 at 11:30 a.m. revealed:<br>-The 3 residents transferred from a sister facility.<br>-She did not know the Resident Registers were incomplete and would complete them right away.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | D 248                                                                                        |                                                                                                                          |                                                        |
| D992                                                       | G.S. § 131D-45 Examination and screening<br><br>G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.<br><br>(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the | D992                                                                                         |                                                                                                                          |                                                        |

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| D992                                                       | <p>Continued From page 3</p> <p>examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 3 of 4 sampled staff (Staff B, C, D) hired after 10/1/13 before the employee began working at the facility.</p> <p>The findings are:</p> <p>Review of Staff B's personnel file revealed:<br/>-Staff B was hired on 12/17/14.<br/>-Staff B was hired as a medication aide/personal care aide.<br/>-No documentation a controlled substance exam/screening had been completed.</p> <p>Interivew with Staff B on 1/16/15 at 1:55 p.m. revealed she had not had any pre-employment drug screening.</p> <p>Refer to interview with the Manager on 1/16/15 at 1:20 p.m.</p> <p>Review of Staff C's personnel file revealed:</p> | D992                                                                                         |                                                                                                                          |                                                        |

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| D992                                                       | <p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-Staff C was hired on 11/10/14.</li> <li>-Staff C was hired as a personal care aide.</li> <li>-No documentation a controlled substance exam/screening had been completed.</li> </ul> <p>Staff B was not available for interview.</p> <p>Refer to interview with the Manager on 1/16/15 at 1:20 p.m.</p> <p>Review of Staff D's personnel file revealed:</p> <ul style="list-style-type: none"> <li>-Staff D was hired on 11/17/14.</li> <li>-Staff D was hired as a personal care aide.</li> <li>-No documentation a controlled substance exam/screening had been completed.</li> </ul> <p>Staff D was not available for interview.</p> <p>Refer to interview with the Manager on 1/16/15 at 1:20 p.m.</p> <p>_____</p> <p>Interview on 1/16/15 at 1:20 pm with the Manager revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for controlled substance exam/screening on new hires.</li> <li>-The three employees had not had the pre-employment substance screening and she was doing a random drug screening next week.</li> <li>-She would have the substance screening completed next week.</li> </ul> | D992                                                                                         |                                                                                                                          |                                                        |