STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIN VILLAGE	999 TABOR ROAD OLIN, NC 28660

(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 Iredell County Department of Social Services conducted an annual and follow-up survey and complaint investigation on July 8-10, 2015. The complaint investigation was initiated by the Iredell County Department of Social Services on May 29, 2015.	D 000		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 898Based on observation and interview, the facility failed to clean and repair a soiled and ripped couch and loveseat in the resident living room. The findings are: Review of the most recent Division of Environment Health Sanitation Inspection Report dated 6/8/15 revealed: - A half point deduction for "furniture clean and in good repair" under the column heading "Furnishings and Patient Contact Items." - Documented comment "furniture in activity room needs repair or replacement...observed several couch and chair cushions with tears; also cloth cushions are not easy to be cleaned..." Observation 7/9/15 at 8:10am of the resident living room revealed: - A loveseat, covered in a blue fabric with stripes,	D 076		

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D 076	Continued From page 1 with numerous rips and tears in the seat cushions. - The largest hole in the seat cushion of the loveseat measured approximately 2 inches by 3 inches which exposed the foam padding. - The armrests and top cushions of the loveseat were heavily stained and soiled with a black/grey appearance. - A couch that matched the loveseat had numerous frayed areas on the seat cushions. - The couch's armrests were heavily stained and soiled with a black/grey appearance. - The couch had an approximately 1 foot long tear between two of the back cushions, exposing the foam padding. Confidential interview 7/9/15 at 8:10am with a resident in the living room revealed residents did sit on the blue fabric couch and loveseat. Observation 7/9/15 at 10:00am of the resident living room revealed a resident lying on the blue fabric couch, asleep. Observation 7/10/15 at 10:10am of the resident living room revealed a resident lying on the blue fabric couch. Interview 7/10/15 at 10:55am with the Maintenance staff member revealed furniture was the responsibility of the Business Office Manager. Interview 7/10/15 at 3:10pm with the Business Office Manager revealed: - She made a verbal request in June with administration to replace the blue fabric covered couch and loveseat. - The couch and loveseat were very soiled and replacements would probably be covered in a vinyl material.	D 076		

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D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 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. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. The findings are: Review of the Health Inspection Report dated 6/8/15 revealed: -The score was 82.5. -Specific observations for identified deductions were documented in the following areas: Flies observed in several shared restrooms, furniture in activity room needs repair or replacement. A. Observation 7/8/15 at 10:44am of the kitchen, dry goods storage room and dining room revealed: - One fly in the kitchen. - One fly in the dry goods storage room. - One fly in the dining room. - An electric insect trap, hanging on the wall but	D 077		

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D 077	Continued From page 3	D 077		

not plugged in.
- The two doors leading into the kitchen from the dining room were propped open.

Observation 7/8/15 at 10:55am in Resident Room #2 revealed:
- Two flies landing numerous times on a resident's face and pants.
- The resident was swatting the fly away that landed on his face.

Observation 7/9/15 at 11:00am in common bathroom #3 revealed a count of 9 flies in the bathroom with no trash and no fecal material in or on the commode.

Observation 7/9/15 at 11:45am in the hallway outside the dining room revealed:
- A count of 13 flies in this area.
- Flies landing on the pant legs of two residents who were swatting them away.

Observation 7/9/15 at 11:50am of the dining room revealed:
- An electric insect trap, hanging on the wall but not plugged in.
- A count of 6 flies with some landing on chair backs, but none landing on residents or food
- The two doors leading into the kitchen from the dining room were propped open.

Interview 7/10/15 at 10:55am with the Maintenance staff member revealed:
- An outside pest control company regularly sprayed around the base of the building (no recent date given).
- Traps were recently placed outside in the trees.
- Replacement bulbs for the electric insect traps were ordered.
- There will "always be flies."

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D 077	Continued From page 4 Interview with the Business Office Manager on 7/10/15 at 3:10pm revealed: -She was aware the facility sanitation score should be maintained at 85 or greater to be in compliance. -Some of the issues which were on the 6/8/15 Health Inspection Report had already been corrected. -The sewer cap outside was busted and a new one had been ordered to repair it. -The dusting problem within the facility had been addressed by purchasing "high dusters" to make it easier for the housekeeping staff to get to ceiling fans and vents throughout the facility. -The filters had been cleaned for the HVAC returns. -Maintenance had repaired all of the baseboard heaters. -She had contacted the county for a reinspection of the facility. -The facility had contracted a pest control company to come into the facility once a week and spray for flies. -The pest control company had hung fly trap bags around the facility to help reduce the number of flies in the facility. -"I plugged all the bug lights back in and have to order 12 replacement bulbs" which would also help to reduce the number of flies in the facility. B. Observation 7/9/15 at 8:10am of the resident living room revealed: - A loveseat, covered in a blue fabric with stripes, with numerous rips and tears in the seat cushions. - The largest hole in the seat cushion of the loveseat measured approximately 2 inches by 3 inches which exposed the foam padding. - The armrests and top cushions of the loveseat	D 077		

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D 077	Continued From page 5 were heavily stained and soiled with a black/grey appearance. - A couch that matched the loveseat had numerous frayed areas on the seat cushions. - The couch's armrests were heavily stained and soiled with a black/grey appearance. - The couch had an approximately 1 foot long tear between two of the back cushions, exposing the foam padding. Observation 7/9/15 at 10:00am of the resident living room revealed a resident lying on the blue fabric couch, asleep. Interview 7/10/15 at 10:55am with the Maintenance staff member revealed furniture was the responsibility of the Business Office Manager. Interview 7/10/15 at 3:10pm with the Business Office Manager revealed: -She was aware the facility sanitation score should be maintained at 85 or greater to be in compliance. -Some of the issues which were on the 6/8/15 Health Inspection Report had already been corrected. -The sewer cap outside was busted and a new one had been ordered to repair it. -The dusting problem within the facility had been addressed by purchasing "high dusters" to make it easier for the housekeeping staff to get to ceiling fans and vents throughout the facility. -The filters had been cleaned for the HVAC returns. -Maintenance had repaired all of the baseboard heaters. -She had contacted the county for a reinspection of the facility. - She made a verbal request in June with administration to replace the blue fabric covered	D 077		

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D 077	Continued From page 6 couch and loveseat. - The couch and loveseat were very soiled and replacements would probably be covered in a vinyl material.	D 077		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, record review and interview, the facility failed to control for excessive numbers of flies in a resident room, a common bathroom, a hallway leading to the dining room and the dining room. The findings are: Review of the most recent Food Establishment Inspection Report dated 5/27/15 revealed: - An overall score of 94. - The facility as out of compliance in the category of "Prevention of Food Contamination," subcategory "insects and rodents not present; no unauthorized animals." - The narrative of the report documented "observed numerous flies throughout kitchen" and	D 079		

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D 079	Continued From page 7 "the presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES [capitalized in the report] by using methods, if pests are found, such as trapping devices or other means of pest control ..." Review of the most recent Division of Environment Health Sanitation Inspection Report dated 6/8/15 revealed: - A half point deduction marked for the category "vermin excluded" under the heading of "Vermin Control, Premises." - A documented comment "flies observed in several shared restrooms..." Review of a packing slip from an electric supply company, dated 6/10/15 and provided by the facility, revealed a quantity of 12 "F15T8/BL Blacklight Lamp" at a designated price with tax. Observation 7/8/15 at 10:50am in hallway outside Resident Room #2 revealed: - An electric insect trap hanging on the wall to the right of the resident room. - One of two florescent tube blue lights was missing from the trap. - The trap was not plugged into the wall and was not operating. - In vicinity of this insect trap was an exit outside to a resident smoking area. Observation 7/8/15 at 10:55am in Resident Room #2 revealed: - Two flies landing numerous times on a resident's face and pants. - The resident was swatting the fly away that landed on his face. Observation 7/8/15 at 10:44am of the kitchen, dry goods storage room and dining room revealed:	D 079		

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D 079	Continued From page 8 - One fly in the kitchen. - One fly in the dry goods storage room. - One fly in the dining room. - An electric insect trap, hanging on the wall but not plugged in. - The two doors leading into the kitchen from the dining room were propped open. Observation 7/9/15 at 8:45am of the hallway outside Room #2 revealed: - The electric insect trap was unplugged. - One of the florescent tube blue lights was missing. - Upon plugging the insect trap into the wall outlet, the light did not come on. Observation 7/9/15 at 11:00am in common bathroom #3 revealed a count of 9 flies in the bathroom with no trash and no fecal material in or on the commode. Observation 7/9/15 at 11:45am in the hallway outside the dining room revealed: - A count of 13 flies in this area. - Flies landing on the pant legs of two residents who were swatting them away. Interview 7/9/15 at 11:45am with Staff D, Personal Care Aide, in the hallway to the dining room revealed: - She concurred with the count of 13 flies in this space. - Flies came in through the door to the outside resident smoking area (located at the end of the hallway by Rooms #1 and #2 and around the corner from the hallway leading to the dining room). Observation 7/9/15 at 11:50am of the dining room revealed:	D 079		

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D 079	Continued From page 9 - An electric insect trap, hanging on the wall but not plugged in. - A count of 6 flies with some landing on chair backs, but none landing on residents or food - The two doors leading into the kitchen from the dining room were propped open. Observation 7/9/15 at 12:05pm of the Business Office Manager revealed: - She was plugging in the electric insect trap outside Room #2 with the device lighting up and going off. - She was jiggling the plug resulted in the device lighting up again and remaining on. Interview 7/9/15 at 12:05pm with the Business Office Manager in the dining room revealed: - The flies came in through the door to the outside resident smoking area (located at the end of the hallway by Rooms #1 and #2 and around the corner from the hallway leading to the dining room). - She concurred with the count of 6 flies in the dining room. Observation 7/9/15 at 12:10pm of the dining room revealed an electric insect trap using, hanging on the wall and plugged in. A second interview 7/9/15 at 12:10pm with the Business Office Manager in the dining room revealed the two doors to the kitchen from the dining room have always been propped open but she was not sure why. Interview 7/10/15 at 10:55am with the Maintenance staff member revealed: - An outside pest control company regularly sprayed around the base of the building (no recent date given).	D 079		

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D 079	Continued From page 10 - Traps were recently placed outside in the trees. - Replacement bulbs for the electric insect traps were ordered. - There will "always be flies." A third interview 7/10/15 at 3:10pm with the Business Office Manager revealed: - An outside pest control company sprayed once a week. - She did not have copies of reports from the outside pest control company as they were all sent to the corporate offices. - Fly trap bags had been placed around the building. - Replacement bulbs for the electric insect traps had been ordered. - She plugged back into electrical outlets all the electric insect traps that had been unplugged. Confidential interviews with 5 residents between 7/8/15 and 7/10/15 revealed: - "In the summer we have lots of flies." - "There are cows close by that causes the flies." - "Sometimes they are worse than at other times." - "They are a bother sometimes." - "I have to swipe them away from my food at times." _____ A plan of protection was obtained from the Business Office Manager on 7/9/15 which called for the facility to do the following immediate actions by 7/10/15: - Call a pest control company. - Invest in fly trap bags for the outside to draw flies out of the facility. - Ordered new bulbs for electric insect traps. - All electric insect traps were turned on. - All bathrooms were to be cleaned daily and as needed.	D 079		

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D 079	Continued From page 11 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 23, 2015.	D 079		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately	D 219		

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available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48

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D 219	Continued From page 13 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 161-170 Aide 68 68 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 171-180 Aide 72 72 48 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 181-190 Aide 76 76 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 191-200 Aide 80 80 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 201-210 Aide 84 84 56 Supervisor 16 16 8 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 211-220 Aide 88 88 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 221-230 Aide 92 92 64 Supervisor 16 16 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. 231-240 Aide 96 96 64 Supervisor 24 24 16 Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call. This Rule is not met as evidenced by:	D 219		

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D 219	Continued From page 14 TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure the required staffing hours were met on third shift (11:00pm to 7:00am) based on census of 54 residents. The findings are: Review of the current facility census of 54 revealed: -Census of 54 residents would require 16 hours of aide coverage on third shift. -A supervisor in the building, or within 500 feet and immediately available on third shift. -The Supervisor's time on duty in the facility could be counted as required aide duty if the facility was sprinklered. Observation on 7/8/15, during the initial tour, revealed the facility did not have a sprinkler system. Telephone interview with Staff G, Personal Care Aide (PCA) on third shift, on 7/9/15 at 8:30am revealed: -"Me and one other" PCA cover third shift. -"Its too many residents for just us..." -A medication aide was "on call" on third shift if a medication needed to be administered during the shift. -"I had to work by myself not last night, but the night before-Tuesday night [7/7/15]." -When she had come in Tuesday night, "they said they were going to have someone come in at 5am to help me get residents up [on 7/8/15]....but nobody came in til 6:30am" on Wednesday (7/8/15). -There were 10 out of 54 residents who required incontinence care on third shift.	D 219		

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D 219	Continued From page 15 -In case of a fire at least 4 of the 54 residents would need a two person assist to get them out of the building. "I couldn't do it by myself." -"That was the first time, I've had to work by myself." -"[Business Office Manager's name] came in one night last week to help me [on the floor]." Review of Staff G's time card entry dated 7/7/15 revealed an in time stamp of Tuesday 10:46pm and an out time stamp of Wednesday 8:21am. Telephone interview with Staff F, PCA on third shift, on 7/9/15 at 10:25am revealed: -There were 5 residents out of 54 residents who required a two person assist for transfers. -She had not worked any on third shift, since she was moved to second shift beginning on 7/5/15. -She stated she had never had to work third shift without another staff to help her. Interview with Staff E, Personal Care Aide, on 7/10/15 at 12:15pm revealed: -Staff E had worked on the morning of 7/8/15. -Staff E had arrived to work at 6:30am. -Staff G and Staff H had worked on third shift 7/7/15. Interview with Staff I, Personal Care Aide, on 7/10/15 at 12:25pm revealed: -On 7/8/15 she had arrived to work at 6:30am. -She thought Staff G and Staff H were there from third shift. -"Normally when I come in they are standing on the porch outside." Interview with Staff A, Medication Aide, on 7/10/15 at 2:37pm and 3:35pm revealed: -She had worked the morning of Wednesday 7/8/15.	D 219		

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D 219	Continued From page 16 -She had come in at 6:47am on 7/8/15. -When she arrived Staff G and two first shift PCAs were working on the floor. -"[Staff H's name,the only other third shift PCA] did not work that night [7/7/15]." -She had "worked a double on Tuesday first and second shift [7/7/15]. I left right at 11pm [7/7/15]. The aides [from second shift] were still here [when she clocked out to go home on 7/7/15]. Interview with Staff D, PCA, on 7/8/15 at 2:00pm and 7/10/15 at 12:21pm revealed: -She had worked first shift on 7/8/15. -She had come in to work at 7am on 7/8/15. -When she arrived she stated Staff G was there, however "I'm not sure if [Staff H's name-other third shift PCA] was here or not." -There are 6 out of 54 residents who required toileting assistance. -There were 3 out of 54 residents who required incontinent care. Interview with the Business Office Manager on 7/10/15 at 10:15am, 11:45am, and 3:10pm revealed: -She lived within 500 feet of the facility and was available to assist third shift staff anytime they needed her. -Staff G had "worked the floor by herself the other night" on third shift. -"I covered third shift on 6/29/15 as floor staff" though she was also coverage as the third shift supervisor. -She stated that she and one PCA had covered third shift on 6/29/15. -She was unaware there were differences with staff requirements for the supervisor requirement when the facility did not have a sprinkler system. -"I changed the schedule five times this pay period [6/24/15 to 7/7/15]."	D 219		

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-"Even though the schedule shows [Staff H's name] working by herself, she didn't. [Staff G's name] was the only worker for one night who worked by herself, and if she had called me I would have come to work."
-"Protocol is if one third shift person calls in either a PCA or [Medication Aide] should have worked over to cover the shift or they should have called me."
-She was in the process of hiring 3 additional PCA staff.

Review of the revised staff schedule dated 7/3/15 provided by the Business Office Manager for dates 6/24/15 to 7/7/15 revealed:
-On 7/4/15, there was one PCA on the schedule for third shift.
-On 7/6/15, there was one PCA on the schedule for third shift.
-On 7/7/15, there were two PCAs on the schedule for third shift.

Confidential interviews with three residents from 7/8/15 to 7/10/15 revealed:
-There were three aides on third shift, but one aide had quit "a few weeks ago." Since then there had only been two aides on third shift. There was no Medication Aide who worked third, so if the resident needed an as needed medication they would ask for the medication before the second shift Medication Aide left. The resident was unaware if only one aide had ever covered the facility without assistance on third shift.
-Two to three staff usually work third shift. Lately only 2 aides have worked. The resident couldn't remember when they went from three aides to two. The resident was not aware if one staff had covered the facility without assistance on third shift.
-Two to three aides normally worked third shift.

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D 219	Continued From page 18 "Last week" started working two aides, but did not know why. The resident was not aware if one staff had covered the facility without assistance on third. Attempted telephone interviews on 7/9/15 and 7/10/15 with Staff H, another PCA on third shift, was unsuccessful by exit. Attempted review of time cards requested on 7/10/15 at 10:15am for two of the third shift PCAs for 6/24/15 to 7/7/15 were not made available by the facility by exit on 7/10/15 at 4:00pm. _____ A plan of protection was submitted by the facility on 7/10/15 and included: -There will be enough Personal Care Aides and Supervisory hours to cover all shifts as required by state regulations. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 23, 2015.	D 219		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to dispose of milk past manufacturer's printed date and to document thaw dates for	D 283		

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D 283	Continued From page 19 supplemental shakes per manufacturer's instructions. The findings are: A. Record review of the Food Establishment Inspection Report dated 5/27/15 revealed: - An overall score of 94. - The facility as out of compliance in the category of "Potentially Hazardous Food Time/Temperature," subcategory of "proper date marking and disposition." - The narrative of the report documented deli turkey and pimento cheese with date marked but "out of date." Observation 7/8/15 at 10:28am of the walk-in fridge in the kitchen revealed: - 4 full unopened gallons of 2 percent milk. - The manufacturer's printed date on all 4 gallons of milk as 7/5/15. Observation 7/8/15 at 10:35am of the reach-in fridge in the kitchen revealed: - 1 full unopened gallon and another partially full gallon of 2 percent milk. - Both the unopened and partially opened gallons of milk had a manufacturer's printed date of 7/5/15. Interview 7/8/15 at 10:40am with Dietary Aide #1 revealed: - Milk was for resident use. - Staff tried to keep 3 gallons in the reach-in fridge and pulled it from the walk-in fridge as needed. Observation 7/8/15 at 12:05pm of lunch service in the dining room revealed one resident with a half a cup of milk at her place setting.	D 283		

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D 283	Continued From page 20 Confidential interview 7/8/15 at 12:05pm with the one resident served milk during lunch service revealed she had drunk her milk. Interview 7/8/15 at 12:08pm of Dietary Aide #1 revealed: - The milk served to the one resident during lunch service was obtained from the opened gallon of 2 percent milk in the reach-in fridge. - She was told by management to use milk up to three days past the date printed on the milk container. - When their food supplier delivered their last supply of milk it was close to the expiration date on the milk containers. Confidential interview 7/8/15 at 12:10pm with the resident served milk during lunch service revealed: - Her milk as served did not taste sour. - She always checked her milk and if it was sour she did not drink it. Interview 7/8/15 at 12:15pm with the Business Office Manager revealed: - Milk was served by kitchen staff up to three days past the date printed on the milk container. - This practice had been in place since she started as manager. - The facility's food supplier made deliveries on Thursdays but they would dump the remaining milk and purchase new milk locally before their next Thursday delivery. B. Observation 7/8/15 at 10:28am of the walk-in fridge in the kitchen revealed: - 15 thawed strawberry flavored supplemental shakes with a manufacturer printed date of 1/22/16.	D 283		

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D 283	Continued From page 21 - 21 chocolate flavored shakes with manufacturer printed date of 6/10/16. - Manufacturer printed instructions on each shake, located in the inner fold of the cartons, directed to use the product after thawing, to store the thawed product at 40 degrees Fahrenheit and to use the product within 14 days of being thawed. - None of the thawed shakes, nor the cardboard boxes they were in, were labeled with either a date they were removed from the freezer or when they would be thawed for 14 days. Observation 7/9/15 at 10:06am during snack time in the dining room revealed: - Four thawed strawberry flavored supplemental shakes. - Manufacturer printed date on the shake cartons was 1/22/16. - None of the thawed shakes were labeled with either a date they were removed from the freezer or when they would be thawed for 14 days. Interview 7/9/15 at 10:06am with Dietary Aide #1 revealed the supplemental shakes were for three named residents "if they come down- sometimes they don't come down" for snack time. Interview 7/9/15 at 11:00am with Dietary Aides #1 and #2 revealed: - One resident did take his supplemental shake at the morning snack time but the other two residents did not come to snack time (they usually slept in late). - When shakes were needed they removed them from the freezer a whole box at a time and placed them in the fridge to thaw. - They did not note the date the shakes were removed from the freezer. - They could not remember the date the current	D 283		

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D 283	Continued From page 22 boxes of strawberry and chocolate shakes in the fridge were removed from the freezer, "maybe a week or so ago." - Upon review of the printed manufacturer instructions on the inside fold of the shake carton, they stated they did not know the shakes were only good for 14 days after thawing. Interview 7/9/15 at 11:05am with the Business Office Manager revealed: - She knew supplemental shakes were stored frozen until needed at which time they were thawed in the fridge. - Upon review of the printed manufacturer instructions on the inside fold of the shake carton, she stated she did not know the shakes were only good after thawing for 14 days. - She would direct the Dietary Aides to discard the currently thawed shakes without a thaw date.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 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 served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure puree consistency diets were served as ordered for 2 of 2 residents (Residents #1 and #9) and nutritional supplements for 2 of 3 residents (Residents #1	D 310		

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D 310	Continued From page 23 and #9). The findings are: A. Review of Resident #1's current FL2 dated 5/8/15 revealed: -Diagnoses included: cerebral vascular accident, osteoarthritis, irritable bowel syndrome, and Parkinson's Disease. -Regular mechanical soft diet -Weigh monthly -Incontinent of bladder and bowel Review of Resident #1's Care Plan dated 7/7/15 revealed Resident #1 was totally dependent on staff for all activities of daily living. 1. Review of Resident #1's physician order dated 5/9/15 revealed: -Regular mechanical soft diet with chopped meats. Review of Resident #1's physician's order dated 5/21/15 revealed regular diet pureed consistency. Review of Resident #1's Licensed Health Professional Support Evaluation dated 6/27/15 revealed: -Increased choking reported to physician on visit on 5/9/15 with orders for modified soft with chopped meats. -On 5/21/15 physician changed diet to puree. -No further choking problems. -Resident has limited range of motion in neck. -Resident fed by staff in bed. Interview 7/8/15 at 11:55am during the lunch service with Dietary Aide #1 revealed: - Resident #1 had a pureed diet ordered and was served in her room.	D 310		

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D 310	Continued From page 24 - The meatloaf on the lunch menu as served was not pureed for these residents as it "falls apart." Observation 7/8/15 at 12:15pm of Resident #1 revealed: -The resident was lying in her bed. -No food or beverages were on her bedside tray table. Observation 7/9/15 at 12:19pm of Resident #1 revealed: - The resident was seated up in bed, being assisted with her meal by Staff I, Personal Care Aide. - The macaroni and cheese on her plate retained its normal shape and consistency and was not pureed. - The vegetable medley was mostly cut up broccoli pieces measuring approximately ½ to 1 inch in length and was not in pureed form. - The barbeque chicken was mostly shredded and was not in pureed form. - A cup of ice tea but no other beverages or supplemental shakes. - The resident was not coughing or choking. Interview with Staff I, Personal Care Aide on 7/9/15 at 11:35am revealed: -She often helped provide feeding assistance for Resident #1. -The resident's appetite was "sometimes good sometimes not." -"She gets in a stage of depression and won't eat well." -"She refuses to eat sometimes." -The resident would refuse to eat "twice a week." -Resident #1 "Doesn't like puree." Interview 7/9/15 at 12:19pm with Staff I, Personal Care Aide, at Resident #1's bedside revealed the	D 310		

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D 310	Continued From page 25 resident's meal was "pureed as best as possible." Interview with Resident #1 on 7/9/15 at 11:15am and 5:00pm revealed: -"When I get upset. I don't eat." -The resident stated she did not have any trouble eating ground or chopped meat or a mechanical soft diet. -"I can eat anything. Had a swallowing study in the hospital and the guy said 'You can swallow better than I can.'" Interview with the Business Office Manager on 7/9/15 at 2:35pm revealed: -"[Staff] came to me today after lunch and said the food processor was broken." -"I knew the plastic cup part [of the processor] was cracked, but didn't know it didn't work at all." -"The plastic cup had been cracked since the middle of June." -"Corporate was supposed to send me a new food processor. They usually order them." -"I will have [a new food processor] in here by supper." -She stated she reported she needed a new food processor to the Corporate office between 6/15/15 and 6/20/15. Interview 7/10/15 at 12:45pm with the Business Office Manager revealed Dietary Aides "knew what to do" with regard to preparing a pureed diet. 2. Review of Resident #1's physician's order dated 5/21/15 revealed house supplements one with meals (breakfast, lunch, and supper). Review of Resident #1's monthly facility documented weights from January 2015 to July 2015 revealed a 41 lbs. weight loss.	D 310		

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D 310	Continued From page 26 Observation 7/8/15 at 12:30pm of the small dry erase board in the kitchen revealed: -Resident #1 with no mention of a supplemental shake. Observation 7/9/15 at 12:19pm of Resident #1 revealed: -The resident was seated up in bed, being fed by Staff G, Personal Care Aide. -A cup of ice tea, but no other beverages or supplemental shakes. Interview with Resident #1 on 7/9/15 at 11:15am and 5:00pm revealed: -"I got a [supplement] this morning." -"Didn't get one for lunch." -"I got one yesterday for lunch." -"The only time I get those is when I don't eat." Interview with Dietary Aide #1 on 7/9/15 at 3:10pm revealed: -Resident #1 had not received a supplement for breakfast or lunch on 7/10/15. -"The aides usually come back and get [Resident #1's] supplements." Interview with Staff F, Personal Care Aide, on 7/9/15 at 4:45pm revealed: -She knew Resident #1 had received a supplement at supper the evening before on 7/8/15. -"I had to go get it when I picked up her tray." Interview with Staff A, Medication Aide, on 7/9/15 at 4:47pm revealed "[The Personal Care Aides] go get a supplement from the kitchen when [Resident #1] doesn't eat a lot." Telephone interview with Resident #1's primary	D 310		

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care physician on 7/10/15 at 9:15am revealed:
-"I don't think she's lost 40 lbs."
-The physician stated he felt that the weights recorded for the resident were not always accurate.
-"I have been seeing her since 1992."
-"She's the same size she's always been."
-"The supplement is typically used as a substitute for a meal when a resident doesn't eat."

B. Review of Resident #9's FL-2 dated 10/9/14 revealed:
- Diagnoses including Alzheimer's dementia.
- "Feeding" was checked in the personal care assistance column with "limited assist[tance]" handwritten.
- Diet was checked with "mech[anical] soft" handwritten.
- An order for a supplemental shake, drink 1 shake three times a day with snacks.

Review of Resident #9's assessment and care plan dated 10/15/14 revealed:
- Nutrition and dietary restrictions documented as "pureed."
- Eating as being totally dependent.

Review of a diet order for Resident #9, signed by the physician and dated 5/21/15, revealed:
- Order options of "regular", "pureed" and "house supplements" checked
- Handwritten next to "house supplements" was "1" and "breakfast", "lunch" and "supper."
- No further documentation in physician or facility notes regarding dietary or swallowing concerns.
- A current 6 month review of monthly weights revealed Resident #9's weights to be stable in the 100 to 110 pound range.

1. Interview 7/8/15 at 11:55am during the lunch

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service with Dietary Aide #1 revealed:
- Resident #9 was ordered a pureed diet and was assisted by staff in the dining room.
- The meatloaf on the lunch menu as served was not pureed for these residents as it "falls apart."

Observation 7/8/15 at 12:00pm in the dining room during lunch service revealed:
- Resident #9 being assisted with her meal by Staff I.
- A whole roll on Resident #9's plate.
- Meatloaf on Resident #9's plate that was not in a pureed form, keeping a cubed shape similar in shape to that served to other residents with regular consistency diets.
- Resident #9 was taking small amounts of food as fed to her without choking or coughing.

Interview 7/8/15 at 12:00pm with Staff I revealed:
- Resident #9 was taking "little bites" of the roll.
- Resident #9 was eating the meatloaf without difficulty as it "crumbles."

Observation 7/9/15 at 12:10pm during the lunch service in the dining room revealed:
- Resident #9 being assisted with her meal by Staff E.
- The macaroni and cheese on her plate was not pureed and retained its normal shape and consistency similar to that served to other residents with regular consistency diets.
- The vegetable medley was mostly cut up broccoli pieces measuring approximately ½ to 1 inch in length and was not in pureed form.
- The barbeque chicken was mostly shredded with cut up pieces measuring approximately ½ to 1 inch in length and was not in pureed form.
- The resident was not coughing or choking.

Interview 7/9/15 at 12:12pm with Staff E in the

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dining room revealed:
- Resident #9 did well eating the vegetable medley and macaroni and cheese in the form presented on the plate.
- Resident #9 needed her meats "cut up."

A second interview 7/9/15 at 12:15pm with Dietary Aide #1 revealed:
- The resident had ordered a pureed diet.
- The facility did not have a blender or food processor.
- If the facility did have a blender or food processor, the macaroni and cheese, her rolls and her meats would have been put in it and pureed.
- She chopped up the meat "the best I could."

A third interview 7/9/15 at 2:50pm with Dietary Aide #1 revealed-
- About a month prior the blade in the kitchen's blender would not work properly.
- This was reported to the Business Office Manager so a new blender or food processor could be obtained.

Interview 7/10/15 at 12:45PM with the Business Office Manager revealed Dietary Aides "knew what to do" with regard to preparing a pureed diet.

2. Observation 7/8/15 at 12:00pm in the dining room during lunch service revealed:
- Resident #9 being assisted with her meal by a staff member.
- No supplemental shake served with Resident #9's lunch.

Observation 7/8/15 at 12:30pm of the small dry erase board in the kitchen revealed Resident #9's name to receive a supplemental shake with all

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D 310	Continued From page 30 meals. Observation 7/9/15 at 12:10pm during the lunch service in the dining room revealed: - Resident #9 being assisted with her meal by Staff E. - No supplemental shakes at her place setting. Interview 7/9/15 at 2:50pm with Dietary Aide #1 revealed: - She did not provide a supplemental shake with Resident #9's lunch. - Personal Care Aides would sometimes get these residents their supplemental shakes. _____ A plan of protection was provided by the facility on 7/9/15 and included: -Business Office Manager went and immediately bought a new food processor. -This ensures residents will be eating the correct diet plans as ordered by the physician. -The Business Office Manager will ensure dietary knows how to prepare therapeutic diets for residents. -All supplement shakes will be served with meals and snacks as ordered. -Personal Care Aides will gather supplemental shakes from the kitchen and ensure residents get those products. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 23, 2015.	D 310		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program	D 317		

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D 317	Continued From page 31 (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide supervised activities as scheduled. The findings are: Observation 7/9/15 at 8:20am of the hallway between the nursing station and medication technician room revealed: - An oversized activity calendar posted on the wall with numerous scheduled activities. - Activities scheduled on this calendar for 7/9/15 was "exercise" at 10:00am and "birdwatching" at 1:00pm. -There were not start and end times listed on the activities to determine how many hours per week the facility had planned for activity hours. -Examples of activities on the calendar were church, exercise, bingo, news, coloring, crafts, socializing, bible study, ring toss, birdwatching, and friendship.	D 317		

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D 317	Continued From page 32 Interview 7/9/15 at 10:00am with Staff D revealed: - Residents would do the exercise activity scheduled for 10:00am in the living room "on their own." - Staff were unavailable to lead this activity unless they completed all of their other duties. Observation 7/9/15 at 10:00am of the resident living room revealed: - 3 residents watching television and no other staff in the room. - One of the residents was stretched out on a couch, asleep. Observation 7/9/15 at 10:05am of the resident living room revealed: - Residents watching television. - No residents exercising. - No staff members facilitating an exercise activity. - An overhead announcement for snack time. Observation 7/9/15 at 10:22am of the resident living room revealed: - 3 residents watching television. - No residents exercising. - No staff members facilitating an exercise activity. Observation 7/9/15 at 10:30am of the resident living room revealed: - No residents exercising. - No staff members facilitating an exercise activity. Observation 7/9/15 at 10:45am of the resident living room revealed: - 3 residents watching television. - No residents exercising. - No staff members facilitating an exercise	D 317		

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D 317	Continued From page 33 activity. Observation 7/9/15 at 1:00pm of the resident living room revealed: - No residents present. - No staff present. Observation 7/9/15 at 1:05pm outside an in front of the facility revealed: - Residents smoking at the designated smoking area. - No residents elsewhere on the grounds in front of the facility. - No staff present. Observation 7/10/15 at 10:05am of the enlarged activity calendar posted in the hallway revealed "Bingo" at 11:00am and "Socializing" from 10:00am through 11:00am. Observation 7/10/15 at 10:10am of the resident living room revealed one resident lying on the blue fabric couch. Observation 7/10/15 at 11:30am of the resident living room revealed: - 3 residents playing bingo with one of the residents calling out numbers. - No staff were present. Confidential interview 7/10/15 at 11:30am with a resident in the living room revealed: - No overhead announcement was made of the current activity. Observation 7/10/15 at 2:25pm of a conversation between a staff member and confidential resident revealed: - The resident asking the staff member where bingo was to be held.	D 317		

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D 317	Continued From page 34 - The staff member walking over to the oversized activity calendar posted in the hallway and stating bingo was held at 11:00AM. - The resident stated she did not know bingo was held at 11:00am and the staff member apologized. - The resident stated she liked bingo and played it in the past. Confidential interviews with ten residents between 7/8/15 and 7/10/15 revealed the following comments: -"We don't have any activities other than we play bingo every two weeks." -"Yes. Sometimes they are offered." -Activities "That's a joke." -"The activity calendar is a lie." -"They are offering bingo every two weeks." -"There [are] not many things to do in the facility." -"If you don't smoke there is not much to do." -"I am ok with what we do here. I can't do much anyway." -"We play bingo sometimes." -"We watch TV, smoke, and talk with each other." -"We don't do anything on the calendar." - "It had been weeks, months since residents had done crafts as there were no supplies." -One resident stated the facility offered bingo on Tuesdays. -Another resident stated they participated in bingo once a week. -Another resident stated the resident council had submitted a list of activities they would like to do to the Business Office Manager on 4/29/15. -The list included activities like pizza parties and ice cream. -The list was faxed to Corporate by the Business Office Manager. Confidential interviews with four staff revealed:	D 317		

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D 317	Continued From page 35 -"Normally if we have an extra Personal Care Aide on the floor then [a Personal Care Aide] will go in and do an activity. We did have an activity lady, but she quit." -The Business Office Manager "is our Activity Director." -The Personal Care Aides "do activities." -The Personal Care Aides "don't do activities." -Some of the residents will "sometimes do bingo." -The Business Office Manager is responsible for activities. -There has been no bingo in "awhile." The staff couldn't remember the last time saw bingo being played by residents, but had seen it being offered before. Interview 7/10/15 at 3:10pm with the Business Office Manager revealed: - She and the personal care aides were responsible for activities and they were being done. - The facility had no activity director but "groups" came to the facility and a resident liked to call out bingo numbers. - Activities should be facilitated by a staff member. - "Selected residents" go out on outings but only a few were wheelchair bound as there was no lift in the van for wheelchairs.	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.	D 319		

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This Rule is not met as evidenced by:
Based on interviews and record review, the facility failed to provide residents with the opportunity to participate in at least one outing every other month.

The findings are:

Confidential interviews with seven residents between 7/8/15 and 7/10/15 revealed the following comments:
-Facility outings "That hasn't been done in awhile."
-"Once a year, we have an outing with the [mental health support group]. We have cookies, hotdogs, and something to drink. The facility [staff] will take us to the store. An outing to the store is offered every two to three weeks."
-"We don't go out anywhere."
-"These walls close in on me."
-"I would like to get out once in awhile."
-"Why can't they take some of us to a [local fast food restaurant]."
-I would like to get out and "get some fresh air and get out of this place."
-One resident stated they "never go on outings." The resident stated he would like to do more outings.
-Another resident stated they had not seen a movie in 2 years and would really enjoy an outing to see a movie.

Interview with the Business Office Manager on 7/10/15 at 3:10pm revealed:
-Outings were offered to residents "two times a month, but only for select people."

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D 319	Continued From page 37 -We "don't take, but only a few wheelchair bound residents." -We "can't get the wheelchairs up and down to get in and out of the [facility] van. There's no lift on the [facility] van."	D 319		
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 observation, interview, and record review, the facility failed to provide repairs to wheelchairs for 6 of 6 residents (Residents #3, #4, #6, #18, #19 and #20). The findings are: A. Record Review for Resident #4 revealed: - FL2 dated 6/8/15 with diagnoses including diabetes mellitus, "non-ambulatory" checked with "W/C" written in and wound care orders three times a week by home health. - A radiology order dated 3/26/15 with the diagnosis of "PAD [peripheral artery disease] with ulcer." - Licensed Health Professional Staff assessment (LHPS) dated 6/27/15 which documented "wound on R [right] heel" with wound care three times a week by home health," ambulates with W/C in hall" and "needs 1 person assist with W/C".	D 338		

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D 338	Continued From page 38 Observation 7/10/15 at 8:45am of Resident #4 revealed: - Resident #4 at the resident smoking area outside, seated in her W/C. - Resident #4's left armrest on her W/C had cracked vinyl covering. - Resident #4's right armrest on her W/C was wrapped in foam padding held in place by dirty gauze dressing and the armrest was leaning outward. - The right wheel brake when engaged was not tight against the wheel of the WC. - Resident #4 was seated on a pillow. - Resident #4's foot was covered in a blue surgical bootie, resting on the right footrest of the W/C with the heel of her foot lying beyond the back of the footrest. - The right footrest was tilted on its frame from front to back with approximately 1 inch of clearance from the bottom of the footrest to the ground. - The woven fabric heel strap on the right footrest of the W/C was missing, with a small piece attached to the outer plastic post on the footrest. - The inner plastic post on the right footrest had no scraps of woven fabric heel strap, but remained sticking up from the footrest and through which the point of a screw was exposed approximately a quarter of an inch and sharp to the touch. Interview 7/10/15 at 8:45am with Resident #4 revealed: - The right armrest of her W/C became broken four months prior. - She has been awaiting a new W/C since May and it took her insurance carrier "a long time." - The right arm rest of her W/C rubbed her arm and the right footrest was too long. - When she was pushed in her W/C her right heel	D 338		

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dragged on the ground.
- She had accidentally stepped on the post with the sharp screw point but it did not puncture her foot.
- The home health nurse was trying to get her a new W/C.
- She was told by (could not remember a name) that the physician ordered a new W/C but " it doesn't seem like [insurance carrier] can get me a new W/C. "
- She needed a W/C cushion.
- There were "too many things wrong with this chair."

Interview 7/10/15 at 10:20am with Staff D, Personal Care Aide, revealed:
- Resident #4 was assisted as needed by staff with transfers to her W/C and supervised with transfers.
- Resident #4 needed a new W/C.
- She thought Resident #4's W/C was hard to push but also thought someone adjusted it so it pushed easier.
- She had never seen Resident #4 drag her heel.
- Night shift staff had assisted her into her W/C and was already in it when she first saw her on her shift.

Interview 7/10/15 at 10:25am with Staff D in the presence of Resident #4 in her W/C revealed:
- The right heel strap on the right footrest was missing.
- The inner post on the right footrest had a screw tip exposed which was sharp.

Phone interview 7/10/15 at 2:35pm with the Licensed Health Professional Staff revealed:
- She was familiar with Resident #4 and was most recently in the facility around 6/27/15 when she did rounds with the physician.

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D 338	Continued From page 40 - She did not recall staff bringing to her attention any problems with Resident #4's W/C. - She knew Resident #4 used a W/C and could transfer to it with one person assistance. - "I don't think the footrest [of the W/C] plays a big part." - Resident #4 had a long history of foot ulcers. Interview 7/10/15 at 3:00pm with the Home Health Nurse revealed: - She had provided wound care for Resident #4 for the previous 3 months. - The Business Office Manager had tried via the durable medical equipment supplier to obtain for the resident a new W/C. - Resident #4 had "good days and bad days" and that current day was having difficulty lifting her leg. - The resident needed a new W/C to "prevent further wounds." Interview 7/10/15 at 12:35pm and 3:10pm with the Business Office Manager revealed: - {Insurance carrier] had refused to give Resident #4 a new W/C and their durable medical equipment supplier or home health would have that paperwork. - Resident #4's W/C is in need of replacement but the resident's "family is refusing." - Resident #4 needed a new W/C. Refer to interview on 7/9/15 at 8:20am with a Staff D, Personal Care Aide. Refer to interview on 7/10/15 at 10:55am with the Maintenance staff member. Refer to interview on 7/10/15 at 3:10pm with the Business Office Manager.	D 338		

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D 338	Continued From page 41 B. Record Review for Resident #3 revealed: - FL-2 dated 9/15/14 with diagnoses including joint pain. - Licensed Health Professional Staff assessment (LHPS) dated 3/28/15 which documented the resident as non-ambulatory with use of a wheelchair (W/C). Observation 7/9/15 at 8:50am of Resident #3 revealed: - Resident #3 in the living room seated in a W/C. - Resident #3's right armrest on his W/C was ripped and missing foam padding. - Resident #3's left armrest vinyl covering was ripped, exposing foam padding which was pulled out of the armrest and extended over the end of the armrest by approximately 2 inches. Based on record review and observation of Resident #3 on 7/9/15, he was determined not to be interviewable. Refer to interview on 7/9/15 at 8:20am with a Staff D, Personal Care Aide. Refer to interview on 7/10/15 at 10:55am with the Maintenance staff member. Refer to interview on 7/10/15 at 3:10pm with the Business Office Manager. C. Record Review for Resident #6 revealed: - FL-2 dated 3/18/15 with diagnoses including arthritis and "non-ambulatory" checked with "W/C" handwritten. - Care plan dated 2/20/15 with ambulation noted as "limited ability" and devices needed as "[with] walker." Observation 7/9/15 at 10:10am of Resident #6	D 338		

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D 338	Continued From page 42 revealed: - Resident #6 in the dining room seated in a W/C. - Resident #6's right armrest on his W/C was ripped and covered in gauze dressing. Interview with Resident #6 on 7/8/15 at 11:15am revealed the resident voiced no complaints concerning his wheelchair. Refer to interview on 7/9/15 at 8:20am with a Staff D, Personal Care Aide. Refer to interview on 7/10/15 at 10:55am with the Maintenance staff member. Refer to interview on 7/10/15 at 3:10pm with the Business Office Manager. D. Record Review for Resident #18 revealed: - FL-2 dated 6/19/15 with diagnoses including syncope and fibromyalgia with "semi-ambulatory" checked and "W/C" handwritten. -Care plan dated 6/19/15 with ambulation status checked as "limited ability" and "ambulatory with aide or device(s)" with device needed as "WC." Observation 7/9/15 at 11:45am of Resident #18 revealed: - Resident #18 in the hallway outside the dining room, seated in her W/C. - Resident #18's armrests on her W/C with tears and exposed foam padding. - Resident #18 declined to answer any questions. Refer to interview on 7/9/15 at 8:20am with a Staff D, Personal Care Aide. Refer to interview on 7/10/15 at 10:55am with the Maintenance staff member.	D 338		

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D 338	Continued From page 43 Refer to interview on 7/10/15 at 3:10pm with the Business Office Manager. E. Record Review for Resident #19 revealed: - FL-2 dated 5/19/15 with diagnoses including dementia and as being ambulatory with "W/C/walker" handwritten. - Licensed Health Professional Staff assessment (LHPS) dated 6/16/15 with the care tasks of "ambulation using assistive devices that requires physical assistance" and "transferring semi-ambulatory or no-ambulatory residents" circled; handwritten was "ambulates [with] W/C." Observation 7/9/15 at 8:18am of Resident #19 revealed: - Resident #19 was wheeled into the living room in her W/C by a Personal Care Aide. - The right armrest of Resident #19's W/C was completely covered in duct tape. - Resident #19 made eye contact but was determined not to be interviewable. Refer to interview on 7/9/15 at 8:20am with a Staff D, Personal Care Aide. Refer to interview on 7/10/15 at 10:55am with the Maintenance staff member. Refer to interview on 7/10/15 at 3:10pm with the Business Office Manager. F. Record Review for Resident #20 revealed: - FL-2 dated 9/26/14 with diagnoses including altered mental status, knee pain and muscle weakness; "wheelchair" was handwritten into ambulatory status box. - Licensed Health Professional Staff assessment (LHPS) dated 3/28/15 with the care tasks of "ambulation using assistive devices that requires	D 338		

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D 338	Continued From page 44 physical assistance" and "transferring semi-ambulatory or no-ambulatory residents" circled. Observation 7/9/15 at 10:30am of Resident #20 revealed: - Resident #20 in the living room seated in a W/C. - Resident #20's right armrest on his W/C was completely covered in duct tape. - Resident #20's left armrest was half covered in duct tape. Interview with Resident #20 on 7/9/15 at 10:30am revealed the resident had no complaints about the condition of his wheelchair. Refer to interview on 7/9/15 at 8:20am with a Staff D, Personal Care Aide. Refer to interview on 7/10/15 at 10:55am with the Maintenance staff member. Refer to interview on 7/10/15 at 3:10pm with the Business Office Manager. _____ Interview on 7/9/15 at 8:20am with a Staff D, Personal Care Aide, revealed if something was broken with a W/C or walker she would inform the medication aide. Interview on 7/10/15 at 10:55am with the Maintenance staff member revealed: - He adjusted brakes on W/Cs. - If W/C problems were beyond his ability he would discuss them with the Business Office Manager. - The facility had W/C footrests and arm pads for replacement. - Staff and residents brought W/C concerns to	D 338		

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D 338	Continued From page 45 him or the Business Office Manager. Interview on 7/10/15 at 3:10pm with the Business Office Manager revealed: - Maintenance staff performed repairs to W/Cs. - The third shift personal care aides were assigned the task of cleaning W/Cs and writing up needed repairs. - She had taped a few armrests on W/Cs. _____ A plan of protection was obtained from the Business Office Manager on 7/10/15 which called for the facility to provide a wheelchair for Resident #4 and to have arms of wheelchairs fixed. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 23, 2015.	D 338		
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 observation, interview, and record review, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to infection control, therapeutic diets and supplements, housekeeping and furnishings, and staffing.	D912		

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D912	Continued From page 46 The findings are: A. Based on observation, record review and interview, the facility failed to control for excessive numbers of flies in a resident room, a common bathroom, a hallway leading to the dining room and the dining room. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation).] B. Based on observation, interview and record review, the facility failed to assure the required staffing hours were met on third shift (11:00pm to 7:00am) based on census of 54 residents. [Refer to Tag 219, 10A NCAC 13F .0606 Staffing Chart (Type B Violation).] C. Based on observation, interview, and record review, the facility failed to assure puree consistency diets were served as ordered for 2 of 2 residents (Residents # 1 and #9) and nutritional supplements for 2 of 3 residents (Residents #1 and #9). [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation).] D. Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring for at least 3 of 20 residents [Resident #3, #10, #11] with orders for finger stick blood sugars (FSBS) by sharing glucometers (a device used to measure the glucose in an individuals blood) with other residents, and one staff reusing disposable gloves when providing personal care for residents residing in the facility. [Refer to Tag 932, G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (Type B Violation.)]	D912		

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D912	Continued From page 47 E. Based on observation and interview, the facility failed to provide repairs to wheelchairs for 6 of 6 residents (Residents #3, #4, #6, #18, #19 and #20). [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation.)]	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the	D932		

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D932	Continued From page 48 potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Type B Violation Based on observations, record reviews, and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring for at least 3 of 20 residents [Resident #3, #10, #11] with orders for finger stick blood sugars (FSBS) by sharing glucometers (a device used to measure the glucose in an individuals blood) with other residents, and one staff reusing disposable gloves when providing personal care for residents residing in the facility. The findings are: Observation of a medication pass on 7/8/15 between 11:10am and 12:00pm of Staff A, Medication Aide (MA) revealed: -She performed two finger stick blood glucose checks using proper infection control technique. -She used each resident's own glucometer and lancing device. -One of the resident's glucometers did not work	D932		

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D932	Continued From page 49 due to a dead battery. -She removed another resident's glucometer to use on the resident [per surveyors request she called the Business Office Manager (BOM) for a new battery]. -BOM provided a new battery for the glucometer and Staff A used the correct glucometer on the resident, after the battery was replaced. Interview on 7/8/15 at 11:20am with Staff A revealed: -She had only been a medication aide for several weeks. -She passed her medication test in June 2015. -Each resident had their own glucometer and lancing device. -She only used each resident's glucometer and lancing device on the resident whose name was on the device. -If there was a glucometer that did not work she would use another resident's glucometer. -She had never shared a resident's lancing device. -She had shared glucometers, when one did not work. -She was unaware if the facility had a replacement glucometer. -She had received diabetic training. -She had taken the State mandated infection control course. Review of Staff A's training records revealed: -She had been hired on 7/23/14. -She had received her medication clinical skills competency validation on 9/16/14. -She had received her State mandated infection control course on 7/17/14. -She had passed the medication test on 6/24/15. -She had received her diabetic care training on 6/27/15.	D932		

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D932	Continued From page 50 Observation on 7/8/15 between 11:00am and 12:30pm of the facility glucometers revealed: -The facility had 20 diabetic residents. -All of the diabetic residents, with the exception of three, had the same type of glucometer. -Each of the diabetic residents had their own glucometer and lancing device. -Each resident's glucometer case, glucometer, and lancing device had been labeled with their name. -Each resident's diabetic supplies were stored in a re-sealable storage bag with their name on the bag. Interview on 7/8/15 at 2:15pm with Staff C, Medication Aide revealed: -Each resident had their own glucometer and lancing device. -If a resident's glucometer was broken she would call [Business Office Manager Name] for instructions. -There was not a replacement glucometer in the facility. -She did not share resident's diabetic equipment. -She had received diabetic training. -She had taken the State mandated infection control training. Review of Resident #3's current FL2 dated 9/15/14 revealed: -Diagnosis of diabetes mellitus. -Daily diabetic testing in the morning. -An admission date of 7/10/05. Review of Resident #3's blood sugar record revealed blood sugar checks every morning. Observation on 7/9/15 between 12:30pm and 12:45pm of Resident #3's glucometer revealed:	D932		

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D932	Continued From page 51 -The correct date and time when the glucometer was powered on by the surveyor. -Resident #3's glucometer had only one July 2015 reading dated July 9, 2015 at 6:35am in the memory, and the resident's blood sugar record for July 2015 had nine readings recorded. -The glucometer's memory had 18 readings from June 2015. -June 22, 2015 had 15 readings ranging from 94 to 248 between 7:08am and 6:00pm. -June 26, 2015 had 3 readings ranging from 150 to 229 between 9:25am and 11:42am. Review of Resident #10's current FL2 dated 4/5/15 revealed: -Diabetes Mellitus-uncontrolled. -Daily diabetic testing in the morning and evening. -An admission date of 5/6/13. Review of Resident #10's blood sugar record revealed blood sugar checks every morning and evening. Observation on 7/9/15 between 12:30pm and 12:45pm of Resident #10's glucometer revealed: -The correct date and time when the glucometer was powered on by the surveyor. -Resident #10's glucometer had only one July 2015 reading dated July 9, 2015 at 7:14am in the memory, and the resident's blood sugar record for July 2015 had 16 readings recorded. -The glucometer's memory had 17 readings from June 2015. -June 23, 2015 had 6 readings ranging from 80 to 211 between 4:44pm and 5:04pm -June 26, 2015 had 3 readings ranging from 111 to 264 between 6:59pm and 7:13pm. -June 28, 2015 had 5 readings ranging from 89 to 270 between 5:08pm and 10:00pm.	D932		

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D932	Continued From page 52 Review of Resident #11's current FL2 dated 1/23/15 revealed: -Diabetes Mellitus. -Daily diabetic testing once weekly. -An admission date of 1/1/14 Review of Resident #11's blood sugar record revealed blood sugar checks every Thursday. Observation on 7/9/15 between 12:30pm and 12:45pm of Resident #11's glucometer revealed: -The correct date and time when the glucometer was powered on by the surveyor. -Resident #11's glucometer had only one July 2015 reading dated July 9, 2015 at 8:54am in the memory, and the resident's blood sugar record for July 2015 had two readings recorded. -The glucometer's memory had 4 readings from June 2015. -June 1, 2015 had 2 readings ranging from 84 to 93 between 8:47am and 8:49am. -June 8, 2015 had 2 readings ranging from 92 to 141 between 8:46am and 8:48am. Interview on 7/9/15 at 1:00pm with Staff B, Medication Aide revealed: -She had always used each residents own glucometer and lancing device. -She had never shared any resident's diabetic equipment. -She had never known a resident's glucometer not to work. -She had received diabetic training. Observation on 7/9/15 of the three randomly sampled resident's blood sugar records for July 2015, revealed the July 9, 2015 readings had been documented correctly by Staff B. Confidential interviews with three diabetic	D932		

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D932	Continued From page 53 residents in the facility revealed: -The MA showed them the "finger stick pen" to see that their name was on it. -Each of the "finger stick pens" were obtained when they came up to the medication room window. -They did see the same "machine" [glucometer] being used sometimes. -They did not have any concerns about the same glucometers being used. -They would not want the same "finger stick pens" to be used on each other. Interview on 7/9/15 at 2:45pm with the BOM revealed: -The facility did not have a written policy on diabetic management of residents. -All the MA had instructed not to share diabetic equipment. -There was not a replacement glucometer in the facility. -She could not explain why the readings on the glucometers and blood sugar records were different. -"The MA must have been sharing glucometers." -She had been unaware of the staff sharing the glucometers. -No staff had ever called her about glucometers not working, or needing a new one. -She was going to have additional training with the medication aides. -She was going to obtain a replacement glucometer to have on hand in case a residents meter did not work. Interview on 7/10/15 at 3:00pm with the BOM revealed: -She had received a replacement glucometer from the pharmacy. -She was going to have training with the MA	D932		

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D932	Continued From page 54	D932		

about infection control and not sharing diabetic equipment.
-The medication aides "know" not to share diabetic equipment.
-All the glucometers had been cleaned with a bleach solution.

By the time of survey exit, the facility had not provided the surveyor with the June 2015 blood sugar records for the three sampled residents.

B. Telephone interview with Staff G, Personal Care Aide (PCA), on 7/9/15 at 8:30am revealed:
-She worked primarily on third shift.
-She stated they "usually" have gloves.
-The Medication Aide on second shift had to check and ensure a supply of gloves were put out for third shift use, because only Medication Aides had keys to the storage area where gloves were kept.
-There were only PCAs in the facility during third shift with a Medication Aide on call if a resident needed a medication given during the shift.
-"If we run out of gloves we can't get no more til the next morning."
-"There's been a night or two where I've had to use the same gloves."
-She stated this had occurred "a month or so ago."
-"Only had one box of gloves put out."
-She stated she put on gloves and used the same gloves for everybody.
-"I would wash my hands with the gloves on and reuse them."

Telephone interview with Staff F, PCA, on 7/9/15 at 10:25am revealed:
-She had worked on third shift until she got moved to second shift on 7/5/15.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D932	Continued From page 55 -She stated she had never run out of gloves when she worked on third shift. Observation of the glove supply available in the medication room on 7/9/15 at 11:30am revealed there were 26 boxes of gloves available. Observation of the glove supply available in the nurses station on 7/10/15 at 2:15pm revealed there were 5 boxes available in the cabinet. Interview with the Business Office Manager on 7/9/15 at 2:35pm revealed: -"No one has ever called me during the night requesting gloves." -"There are always some gloves left out at the nurses station so anyone can get to them." Confidential interview with four additional staff from 7/8/15 to 7/10/15 revealed none of the other staff reported ever having run out of gloves to provide personal care to the residents. Confidential interviews with four residents on 7/8/15 to 7/10/15 revealed: -4 of 4 residents agreed staff consistently wore gloves to provide incontinent care. -1 of 4 residents was sure staff removed the gloves after care, threw the gloves away, and washed their hands. -"I don't really watch" what staff do with the gloves after providing care. Attempted telephone interview with Staff H, another PCA who routinely worked third shift, on 7/9/15 and 7/10/15 was unsuccessful by exit. --- The facility provided the following plan of	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049016	A. BUILDING: _____ B. WING _____	R 07/10/2015

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D932	Continued From page 56 protection on 7/9/15. -All glucometers were sterilized with bleach water mixture 1 to 10 solution and let air dry before using on residents. -All residents will have glucometers used only for assigned residents. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 23, 2015.	D932		