STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084001	A. BUILDING: _____ B. WING _____	10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOUSE	319 PALMER STREET ALBEMARLE, NC 28001

(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 conducted an annual survey on October 27 and 28, 2015.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure completion of an approved Cardio-Pulmonary Resuscitation (CPR) and choking course within the last 24 months for 4 of 4 staff sampled (Staff A, B, D and E). The findings are: A. Review of Staff A's personnel file revealed: - A hire date of 05/08/99. - Staff A worked as a Nurse Aide/Medication Aide (NA/MA). - CPR certification was provided by an online training company.	D 167		

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	HAL084001	A. BUILDING: _____ B. WING _____	10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOUSE	319 PALMER STREET ALBEMARLE, NC 28001

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D 167	Continued From page 1 - CPR certification with an expiration date of 03/08/16. Interview on 10/27/15 at 3:15 pm with Staff A revealed: - The CPR was provided as an online course and did not include any hands-on training or practice with manikins. Refer to interview with the Administrator on 10/28/15 at 11:00 am. B. Review of Staff B's personnel file revealed: - A hire date of 08/20/07. - Staff B worked as a Nurse Aide/Medication Aide. - CPR certification was provided by an online training company. - CPR certification with an expiration date of 10/27/17. Staff B was unavailable for interview. Refer to interview with the Administrator on 10/28/15 at 11:00 am. C. Review of Staff D's personnel file revealed: - Staff D worked at the facility as a Nurse Aide/Medication Aide. - CPR certification was provided by an online training company. - CPR certification with an expiration date of 5/20/17. Interview on 10/28/15 at 9:50 am with Staff D revealed: - She worked at the facility for 1 year and 3 months. - She was CPR certified. - Her CPR training was completed online and consisted of a videos and a test, the training had	D 167		

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	HAL084001	A. BUILDING: _____ B. WING _____	10/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOUSE	319 PALMER STREET ALBEMARLE, NC 28001

(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 167	Continued From page 2 no hands-on component. Refer to interview with the Administrator on 10/28/15 at 11:00 am. D. Review of Staff E's personnel file revealed: - Staff E worked as a Nurse Aide/Medication Aide. - CPR certification was provided by an online training company. - CPR certification with an expiration date of 2/17/17. Interview on 10/28/15 at 10:15 am with Staff E revealed: - She had worked at the facility as a Nurse Aide/Medication Aide for 13 years. - She was CPR certified. - When she was certified in CPR earlier this year, it was an online course and did not include any hands-on training with manikins. Refer to interview with the Administrator on 10/28/15 at 11:00 am. Interview with the Administrator on 10/28/15 at 11:00 am revealed: - For at least 4 years the facility had provided the online CPR training for all employees. - No additional CPR training had been provided to the employees. - The facility was staffed with Nurse Aides/Medication Aides and CPR was required for employment. - All CPR training was completed on line and did not include a hands-on component for any of the employees.	D 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092142	A. BUILDING: _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE ASSISTED LIVING COI	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 conducted an annual survey on October 14-15, 2015.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interview and review of personnel record, the facility failed to assure 1 (Staff B) of 3 staff sampled were tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Staff B's personnel record revealed: -She was hired as a personal care aide on 5/3/12. -Documentation of a TB skin test given on 10/14/11 and read on 10/17/11 as negative. -Documentation of another TB skin test given on 2/28/13 and read on 3/4/13 as negative. -No documentation of a 2-step TB skin test within 12 month period. Staff B was unavailable for interview.	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092142	A. BUILDING: _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RIVER VILLAGE ASSISTED LIVING COI	1110 FALLS RIVER AVENUE RALEIGH, NC 27614

(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 131	Continued From page 1 Interview with the Executive Director (ED) on 10/15/15 at 3:30 p.m. revealed: -She could not find documentation of a 2-step TB skin test within 12 month period. -The Assisted Living Director (ALD) was responsible for making staff had a 2-step TB skin test. -The ALD no longer worked at the facility. -1st step TB skin test should be done prior to hire. -2nd step TB skin test should be done between 2-3 weeks after hire. -She would be responsible for making sure Staff B completed the 2-step TB skin test.	D 131		