STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011195	A. BUILDING: _____ B. WING _____	02/16/2016

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C 000	Initial Comments The Adult Care Licensure Section and Buncombe County Department of Social Services conducted an annual survey and a follow-up survey on February 12, 2016 and February 16, 2016.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, 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. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure three live-in non-residents (Family Member #1, #2 and #3) and one employee (Staff A) were tested upon employment and/or residing in the facility, for tubercular disease (TB) in compliance with control measures adopted by the Commission for Health Services.	C 140		

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C 140	Continued From page 1 The findings are: Observation during the survey on 2/12/16 and 2/16/16 revealed the census to be 5 female residents. The three live-in non-resident Family Members #1, #2 and #3 were not in the facility. A. Review of Staff A's personnel record revealed: -A hire date of 10/2/15 as a Supervisor-in-Charge. -A copy of a TB test dated 10/4/15 with a negative result. -There were no other TB documentation in the personnel record. Interview with Staff A on 2/12/16 at 3:15pm revealed: -She had been screened for TB in her country of origin, prior to coming to the United States on 10/1/15. -The screening was on a disk which contained copies of her medical records from her country of origin. -The disk had been kept in her living quarters at the facility. Observations of Staff A on 2/12/16 and 2/16/16 revealed she provided personal care for the residents including bathing and incontinence care and prepared and served the resident's meals. Interview with the Administrator on 2/12/16 at 4:10pm revealed: -She had not reviewed the disc containing Staff A's TB screening, completed in her country of origin. -She would check the disk and print verification of the previous TB test. -She was a Licensed Practical Nurse (LPN) and she performed the TB testing for all staff, residents and live-in non-residents at the facility.	C 140		

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C 140	Continued From page 2 -She had not completed a second step TB test for Staff A because she knew Staff A had been screened for TB prior to leaving her country of origin and thought only one test was necessary. Interview with the Administrator on 2/16/16 at 11:45am revealed: -She had reviewed the disk containing Staff A's health records from her country of origin, and there had been "just a chest x-ray." -She indicated the chest x-ray was non-specific for TB. -There had been no documentation a TB skin test had been completed. -She had completed the first step TB test for Staff A on 2/12/16. Review of Staff A's personnel record on 2/16/16 revealed a first step TB test, read on 2/15/16, had been negative. Review of the facility's TB policy on 2/16/16 revealed TB testing was required for staff upon employment with Step 2 being given two to three weeks after Step 1. There were three non-resident family members living in the facility (Family Members #1, #2 and #3). B. Interview with the Administrator on 2/12/16 at 4:10pm revealed: -Family Member #1 had been living at the facility since "around 2/3/16." -He had been visiting from his country of origin and she was unsure how long he would be staying. -He was not employed by the facility. -There was no personnel record for Family Member #1.	C 140		

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C 140	Continued From page 3	C 140		

-She thought a TB test had been completed prior to him leaving his country of origin.
-She would check records for any verification of TB testing.
-She had not completed a TB test for Family Member #1.

Interview with the Administrator on 2/16/16 at 11:45am revealed:
-She had checked records and had not located previous TB testing for Family Member #1.
-She was a Licensed Practical Nurse (LPN) and she performed the TB testing for all staff, residents and live-in non-residents at the facility.
-She had completed a first step TB test for Family member #1 on 2/12/16.

Review of the results of the TB test for Family Member #1 on 2/16/16 revealed:
-It had been completed by the Administrator on 2/12/16.
-It had been read as negative on 2/15/16.

C. Interview with the Administrator on 2/12/16 at 4:10pm revealed:
-Family Member #2 had been living at the facility since 10/1/15.
-There was no personnel record for Family Member #2.
-She thought a TB test had been completed prior to his leaving his country of origin.
-She would check records for verification of TB testing.
-She was a Licensed Practical Nurse (LPN) and she performed the TB testing for all staff, residents and live-in non-residents at the facility.
-She had completed a TB test for Family Member #2 on 10/1/15.

Review of the results of the TB test for Family

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C 140	Continued From page 4 Member #2, completed 10/1/15, revealed it had been read as negative on 10/4/15. Interview with the Administrator on 2/16/16 at 11:45am revealed: -She had checked records and no previous TB test had been located for Family Member #2. -She had completed a first step TB test on 2/12/16. Review of the results of the TB test for Family Member# 2, completed on 2/12/16, revealed it had been read as negative on 2/15/16. D. Interview with the Administrator on 2/12/16 at 4:10pm revealed: -Family Member #3 had been living at the facility since 10/1/15 -Family Member #3 was a minor. -She thought a TB test had been completed prior to his leaving his country of origin. -She would check records for verification of TB testing. -She was a Licensed Practical Nurse (LPN) and she did the TB testing for all staff, residents and live-in non-residents at the facility. -She had completed a TB test for Family Member #3 on 10/1/15. Review of the results of the TB test for Family Member #3, completed 10/1/15, revealed it had been read as negative on 10/4/15. Interview with the Administrator on 2/16/16 at 11:45am revealed: -She checked records and did not locate a previous TB test for Family Member #3. -She had completed a first step TB test on 2/12/16.	C 140		

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C 140	Continued From page 5 Review of the results of the TB test for Family Member #3, completed 2/12/16, revealed it had been read as negative on 2/15/16. _____ A Plan of Protection was provided by the facility on 2/12/16 and included the following: -The Administrator will assure the first step of the two step TB test is completed for all staff and live-in non-residents prior to living in the facility. -A second step TB will be completed 2 to 3 weeks after the first step TB. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 1, 2016.	C 140		
C 142	10A NCAC 13G .0406 (2) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications Each staff person of a family care home shall: (2) be able to apply all of the home's accident, fire safety and emergency procedures for the protection of the residents; This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to ensure the facility staff would be able to apply the home's emergency fire procedure for 1 of 1 sampled residents (Resident #1) who was totally dependent on the staff for transfers and wheelchair mobility.	C 142		

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C 142	Continued From page 6 The findings are: Review of Resident #1's current FL2 dated 1/19/16 revealed: -Diagnoses included history of left CVA (a cerebral vascular accident or stroke resulting in left sided paralysis), probable vascular dementia and obesity. -No information related to orientation status. -She was non-ambulatory. -No documentation regarding the use of assistive devices. -No documentation of mechanical lift use. mechanical lift was not listed. Review on 2/12/16 of the Resident Register revealed an admission date of 4/26/06. Review of Resident #1's current Assessment and Care Plan dated 6/30/15 revealed: -Her orientation had been documented as "sometimes disorientated." -Her memory had been documented as "forgetful." -She was dependent on the staff for toileting, bathing, dressing, grooming and transfers. Review of Resident #1's record revealed a physician's order for a mechanical lift dated 9/1/14. Review of Licensed Health Professional Support (LHPS) forms completed quarterly in January 2015, March 2015, July 2015 and October 2015 indicating the mechanical lift had been in use. Review of Resident #1's current LHPS form dated 1/15/16 revealed: -"The resident must be transferred via a	C 142		

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C 142	Continued From page 7 mechanical lift due to inability to transfer self with staff assist due to paralysis". -"Staff has been checked off for competency in this skill after trainings in October 2015 and December 2015." -"[The resident] requires total assist with ADLs (activities of daily living) and transfers." Observations on 2/12/16 revealed no mechanical lift was located in the facility. Interview on 2/12/16 at 10:05am with Resident #1, via an interpreter, revealed: -She was out of bed twice a week for a shower. -She was out of bed once a week for church. -She did not get out of bed for meals. -The person getting her out of bed did not use the mechanical lift. -The person getting her out of bed was the Property Manager who lived in another building. -Staff A, Supervisor-in-Charge (SIC) did not get her out of bed. Interview on 2/12/16 at 10:35am with Staff A, SIC, revealed: -She had been employed at the facility since 10/2/15. -She had been trained to use the mechanical lift for Resident #1. -She had been trained two staff were necessary when using the lift. -She had used the mechanical lift with Resident #1, "once or twice." -She was the only staff in the home at night. -The lift was" big and too much for her to use by herself because she was so small." -She felt Resident #1 was too big (heavy) for her to get out of bed by herself. -The Property Manager would get Resident #1 up for her showers and for church.	C 142		

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C 142	Continued From page 8 -The Property Manager did not use the mechanical lift when getting the resident out of bed. -He did not get the resident out of bed for meals. -If there were a fire in the facility, Staff A felt she was not strong enough (too small) and Resident #1 too heavy for her to get out of bed and out of the facility by herself. Interview on 2/12/16 ay 3:50pm with the facility Administrator revealed: -She was not aware the SIC could not manage the lift by herself. -She was not aware the SIC felt she would not be able to get Resident #1 out of bed and out of the facility if there was a fire. -She was not aware the Property Manager had been physically transferring Resident #1. -She was not aware Resident #1's mechanical lift had been left in the chapel after the December 2015 training. -Resident #1 had not experienced any falls or injuries as a result of staff not using the mechanical lift for transfers. Telephone interview on 2/15/16 at 9:15am with the facility Nurse Consultant, from the staffs' country of origin, revealed: -She had been at the facility the end of December 2015 to train the staff on the use of the mechanical lift. -Resident #1's mechanical lift had been moved to the chapel for the training. -Per facility policy, two staff members (at least) were required to be present when the lift was used. -She had not been back to the facility since the December 2015 staff training. -She was not aware the mechanical lift had not been brought back to the resident's room.	C 142		

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C 142	Continued From page 9 -She was not aware the staff had not been using the lift. Telephone interview on 2/15/16 at 2:05pm with a nurse from the pharmacy, who was responsible for completing the LHPS forms, the staff LHPS training and staff competency validation, revealed: -In September 2015 or October 2015, she had completed LHPS training and competency validation for all employees (12 or 13) on the mechanical lift. -The facility nurse consultant, a Registered Nurse from the staffs' country of origin, had attended the training as an interpreter. -The staff had been trained to have two people present during transfers with the mechanical lift. -She stated, "It was not always possible to have two people present during the transfer in the smaller homes." -When in the facility to assess Resident #1 in order to complete the LHPS form, she would interview the staff and resident to ensure the lift was being used and used properly by the staff. -She had last assessed Resident #1 and completed an LHPS on January 15, 2016. -Through hand gestures, she had been able to determine the lift was being used by the staff, it was bring used properly and the sling had been placed correctlyand had not pinched the resident's hips. Interview on 2/16/16 at 12:30pm with the Property Manager revealed: -He had worked at the facility for three years. -He had been trained on using the mechanical lift by a nurse in the Fall of 2014. -He stated it was easier to physically lift Resident #1 out of the bed because the lift was" very difficult to use."	C 142		

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C 142	Continued From page 10 -He would sit Resident #1 up on the edge of her bed and she would hold his neck with her "good arm". -He would then put his arms around her middle and swing her into the shower chair or wheelchair. -He stated if there was a fire at night, it would take him several minutes to get to the facility to help with Resident #1. -He stated he did not think Staff A, SIC, would be able to remove Resident #1 from the facility in an emergency, without help, because Resident #1 was bigger (heavier) than the staff person. Interview on 2/16/16 at 2:45pm with the Administrator revealed: -She was not aware the Property Manager felt Staff A,SIC, would not be able to move Resident #1 out of the facility in an emergency. -Resident #1 required a lot of care. -The resident's family did not want her moved to a higher level of care away from her current environment. -She (the Administrator) and the resident's family felt a move "like that" would cause her much stress and she would decline and die sooner. -She stated if she keeps the residents in their current environment, as they aged more staff would be required to meet their needs, especially at night. -During the day, there was plenty of staff available to assist Staff A, SIC, if Resident #1 wanted to get out of bed. -She would begin looking for additional help, hopefully couples who could be trained and then live at the facility, so there would be extra help at night. Review on 2/16/16 of the facility mechanical lift policy, through an interpreter, revealed:	C 142		

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C 142	Continued From page 11 -The policy was not dated. -The policy did not specify two staff were required when the lift was in use. _____ A Plan of Protection was provided by the facility on 2/12/16 and included the following: -The mechanical lift would be returned to the facility tonight. -Two trained staff will remain in the facility at night, who are trained on facility accident, fire safety and emergency procedures, for the protection of the residents. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 17, 2016.	C 142		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure referral and follow-up to meet the routine health care needs for 2 of 3 sampled residents concerning pain preventing her from sitting in her wheelchair (Resident #1) and obtaining a hemoglobin A1C test (test used to measure the average blood glucose levels)(Resident #3). The findings are: A. Review of Resident #1's current FL2 dated 1/19/16 revealed:	C 246		

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C 246	Continued From page 12 -Diagnoses included history of left CVA (a cerebral vascular accident or stroke), probable vascular dementia and obesity. -She was non-ambulatory. Review of the Resident Register revealedan admission date of 4/26/06. Interview on 2/12/16 at 10:05am with Resident #1, via an interpreter, revealed: -She was out of bed twice a week for a shower and once a week for church. -The person getting her out of bed was the Property Manager. -Staff A, Supervisor-in-Charge (SIC) did not get her out of bed. -She would like to get up in her wheelchair and out of her room more. -"Unfortunately, her behind starts to hurt shortly after she gets in the wheelchair and she has to go right back to bed." Interview on 2/12/16 at 10:35am with Staff A, SIC, revealed: -She had been employed at the facility since 10/2/15. -Resident #1 was too heavy for her to get out of bed by herself. -The Property Manager was not always available to get the resident up in her wheelchair at other times. -When the resident gets in the wheelchair, "her bottom begins to hurt and she wants to go right back to bed." -The resident had a small red rash on her back but nothing on her behind. -She ate all of her meals in bed. Interview on 2/12/16 at 3:50pm with the Administrator revealed:	C 246		

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C 246	Continued From page 13 -She was aware Resident #1 could not stay up in her wheelchair very long before her bottom began to hurt and she asked to go back to bed. -The Nurse Practitioner had not been informed of the pain. -The resident had a history of a small rashy area (no pain associated with it) on her mid-back from dampness/moisture and a cream had been ordered for it. Interview on 2/16/16 at 12:30pm with the Property Manager revealed: -He had worked at the facility for three years. -He was responsible for putting Resident #1 in her wheelchair. -The resident was out of bed for showers twice a week and for church once a week. -The resident stayed in bed because when she was in the wheelchair she would say her bottom hurt and she wanted to go back to bed. Interview on 2/16/16 at 2:45pm with the Administrator revealed: -The staff had gotten Resident #1 out of bed and into her wheelchair in the past but she couldn't stay up long before her bottom hurt and she wanted to go back to bed. -She did not know why the resident's bottom hurt. -On one occasion, the staff had taken the resident from her wheelchair and placed her on the couch in the living room hoping she would be more comfortable. -She could not remain upright and was returned to bed. -She had not had the prior Physician or the current Nurse Practitioner assess the resident's pain. -She had not asked the Nurse Practitioner for an order for Occupational Therapy to evaluate the resident and the wheelchair for positioning.	C 246		

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	FCL011195	A. BUILDING: _____ B. WING _____	02/16/2016

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C 246	Continued From page 14 -She would speak with the Nurse Practioner, who was on-site, and get an order for therapy to evaluate and treat Resident #1. B. Review of Resident #3's current FL2 dated 11/3/15 revealed a diagnosis of Type II Diabetes. Review of Resident #3's record revealed: -A physician's order dated 11/3/15 for an A1C test (a test used to measure the average blood glucose levels). -There were no results documented in the record of an A1C having been drawn. Interview with the Administrator on 2/12/16 at 2:30pm revealed: -She thought the A1C had been completed. -She would check the records. Interview with the Administrator and the Nurse Practitioner for the facility on 2/16/16 at 11:35am revealed: -There had recently been problems with the laboratory used for blood draws. -The Nurse Practioner was aware the A1C had not been drawn by the lab when ordered. -Another lab was being contacted to provide services to the facility. -It was the Administrator's responsibility to follow-up on lab orders to ensure they were completed. -They would re-schedule the blood draw immediately. Review of the Licensed Health Professional Support (LHPS) evaluations revealed: -On 10/13/15, documentation "MD monitors A1C" and diabetes "stable." -On 1/15/16, documentation "Diabetes stable", "no results in chart for A1C."	C 246		

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C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family 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: Based on observation, record review and interview, the facility failed to assure 1 of 1 sampled residents (Resident #1) was treated with full consideration of her desire to interact with other residents in the facility. The findings are: Review on 2/12/16 at 10:00am of Resident #1's current FL2 dated 1/19/16 revealed: -Diagnoses included history of left CVA (a cerebral vascular accident or stroke), probable vascular dementia and obesity. -No information related to orientation status. -She was non-ambulatory. -No documentation regarding the use of assistive devices. Review of the Resident Register revealed an admission date of 4/26/06. Review of Resident #1's current Assessment and Care Plan dated 6/30/15 revealed: -Her orientation had been documented as "sometimes disorientated." -Her memory had been documented as "forgetful." -She was dependent on the staff for toileting, bathing, dressing, grooming and transfers.	C 311		

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C 311	Continued From page 16 Review of Resident #1's record revealed: -An order for a mechanical lift dated 9/1/14. -Licensed Health Professional Support (LHPS) forms completed quarterly in January 2015, March 2015, July 2015 and October 2015 indicating the mechanical lift had been in use. Review of Resident #1's current LHPS dated 1/15/16 revealed: -"The resident must be transferred via a (Brand name) Lift, a mechanical lift, due to inability to transfer self with staff assist due to paralysis." -"Staff has been checked off for competency in this skill." -"[The resident] requires total assist with ADLs (activities of daily living) and transfers." Review of a note written by the facility's new primary care provider on 12/1/15 revealed: -Resident #1 "using reclining wheelchair on occasion, mostly for church." -The resident was "getting out of bed more into the wheelchair." Observations on 2/12/16 revealed no mechanical lift was found in the facility. Interview on 2/12/16 at 10:05am with Resident #1, via an interpreter, revealed: -She was out of bed twice a week for a shower. -She was out of bed once a week for church. -She would like to get up in her wheelchair and out of her room more. -She would like to go to the living room and be around the other residents. -She thought she would like eating at the dining room table with the other residents. -"Unfortunately, her behind starts to hurt shortly after she gets in the wheelchair and she has to go	C 311		

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C 311	Continued From page 17 back to bed. Interview on 2/12/16 at 10:45am with Resident #1, via an interpreter, revealed: -She was in her bed and heard singing and laughter from the living room. -The singing was in the language of her country of origin. She would have liked to be part of the activity. -She had not been asked if she would like to participate. -The staff left the door to her room open so she could hear the singing. Interview on 2/12/16 at 10:35am with Staff A revealed: -She knew the mechanical lift was to be used to get Resident #1 out of bed. -She had been trained to use the lift for Resident #1. -She had been trained two staff were needed when using the lift. -She had used the lift with Resident #1, "once or twice". -She was the only staff working in the home unless she called for assistance -The lift was big and too much for her to use by herself. -Resident #1 was too heavy for her to get out of bed by herself. -The Property Manager would get Resident #1 up for her showers and for church. -The Property Manager did not use the lift when getting the resident out of bed. -The Property Manager was not always available to get the resident up in her wheelchair at other times. -The resident was not gotten out out of bed unless the property manager was available to do it.	C 311		

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C 311	Continued From page 18 Interview on 2/12/16 ay 3:50pm with the facility Administrator revealed: -She was not aware the Property Manager had been physically transferring Resident #1 and not using the lift. -She was not aware the mechanical lift had been left in the chapel after the December training. -She was aware Resident #1 could not stay up in her wheelchair very long before her bottom began to hurt and she asked to go back to bed. -She was aware the resident spent most of her time in her room looking out the window or watching television programs from her country of origin. Interview on 2/16/16 at 12:30pm with the Property Manager revealed: -He had worked at the facility for three years. -He had been trained how to use the mechanical lift by a nurse in the Fall of 2014. -He stated it was easier to physically lift Resident #1 out of the bed because the mechanical lift was very difficult to use. -He lifted the resident to and from her wheelchair once a week for church. -He had lifted the resident into her wheelchair to go to the dining room for a meal after Christmas but not since that time. -In the warmer weather, he lifted her into her wheelchair to go outside for a walk. -He had responsibilities that often took him away from the facility. -He could not always be available to get Resident #1 up when she wanted. Interview on 2/16/16 at 2:45pm with the Administrator revealed: -The staff had gotten Resident #1 out of bed and into her wheelchair in the past.	C 311		

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C 311	Continued From page 19 -The resident wouldn't be up long before she said her bottom hurt and she wanted to go back to bed. -She did not know the resident's bottom hurt. -On one occaison, the staff had taken the resident from her wheelchair and placed her on the couch in the living room. -She could not remain upright and was returned to bed. -She had not had the Physician assess the resident's pain. -She had not asked for a physician's order for Occupational Therapy to evaluate the resident and the wheelchair for positioning. -She would speak with the Nurse Practioner, who was on-site, and get an order for therapy to evaluate and treat Resident #1. Observation on 2/16/16 at 10:30am revealed the mechanical lift had been brought back to the facility and was in an empty room across the hall from Resident #1's room.	C 311		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 that every resident receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and	C 912		

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C 912	Continued From page 20 regulations related to testing for tubercular disease and applying emergency fire procedures A. Based on interviews and record reviews, the facility failed to ensure three live-in non-residents (Family Members #1, #2 and #3) and one employee (Staff A) were tested upon employment and/or residing in the facility, for tubercular disease (TB) in compliance with control measures adopted by the Commission for Health Services. [Refer to Tag 140, 10A NCAC 13G .0405(a)(b) Testing for Tuberculosis (Type B Violation)]. B. Based on record reviews and interviews, the facility failed to ensure the facility staff would be able to apply the home's emergency fire procedure for 1 of 1 sampled residents (Resident #1) who was totally dependent on the staff for transfers and wheelchair mobility. [Refer to Tag 142, 10A NCAC 13G .0406(2) Other Staff Qualifications (Type A2 Violation)].	C 912		