STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

(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 and a complaint investigation on July 27-29 and August 1, 2016.	D 000		
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305Physical Environment (d) The requirements for the bedroom are: (1) The number of resident beds set up shall not exceed the licensed capacity of the facility; (2) There shall be bedrooms sufficient in number and size to meet the individual needs according to age and sex of the residents, any live-in staff and other persons living in the home. Residents shall not share bedrooms with staff or other live-in non-residents; (3) Only rooms authorized as bedrooms shall be used for residents' bedrooms; (4) Bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved for a resident's bedroom; (5) There shall be a minimum area of 100 square feet excluding vestibule, closet or wardrobe space in rooms occupied by one person and a minimum area of 80 square feet per bed, excluding vestibule, closet or wardrobe space, in rooms occupied by two people; (6) The total number of residents assigned to a bedroom shall not exceed the number authorized for that particular bedroom; (7) A bedroom may not be occupied by more than two residents. (8) Resident bedrooms shall be designed to accommodate all required furnishings; (9) Each resident bedroom shall be ventilated with one or more windows which are maintained operable and well lighted. The window area shall	D 049		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 049	Continued From page 1	D 049		

be equivalent to at least eight percent of the floor space and be provided with insect screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and
(10)Bedroom closets or wardrobes shall be large enough to provide each resident with a minimum of 48 cubic feet of clothing storage space (approximately two feet deep by three feet wide by eight feet high) of which at least one-half shall be for hanging clothes with an adjustable height hanging bar.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to provide living arrangements to meet the needs of the residents by installing a wall and a door which dissected Room #4 and creating a room not directly off a corridor and only accessible through the remaining portion of Room #4.

The findings are:

Observations of the facility bedrooms on 7/27/16 at 9:15am revealed:
-Room #4 was at the end of a short hall off the main hallway.
-There were three beds in the room, two were occupied by female residents and one was unoccupied.
-The facility had installed a wall and a door on the right side of the room which dissected Room #4 and created a room not directly off a corridor and only accessible through the remaining portion of Room #4.
-There was a lattice insert in the left side of the wall obscured by a resident wardrobe.

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 049	Continued From page 2 Interviews with the female residents living in Room #4 revealed the small room had been there "at least ten years". Review of the facility's original floor plan revealed: -Room #4 had been one large room. -It had been approved for 4 residents. -The wall and the door dissecting Room #4 were not on the original floor plan. Interview on 7/29/16 at 12:59pm with a Supervisor from the Construction Section revealed: -They were not aware changes had been made to Room #4. -The floor plan on file was the original floor plan and did not reflect the changes that had been made within the room. -The changes had not been reviewed by construction. Interview on 7/27/16 at 3:20pm with the Executive Director revealed: -The facility had made the changes to Room #4 "at least 10 years ago, if not more". -"It wasn't really a room because of the lattice in the wall". -The Resident living in the room had just lost her son when she was admitted. -The room had been made to give her some privacy and her own space.	D 049		
D 058	10A NCAC 13F .0305(f)(6) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (6) Storage for Resident's Articles. Some means	D 058		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 058	Continued From page 3 for residents to lock personal articles within the home shall be provided; and This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a lockable space for the security of personal articles for 17 of 19 residents living in the facility. The findings are: Observations on 5/27/16 10:05am of the resident rooms revealed: -Room 1 contained two residents and three bedside stands each with a lockable drawer. One resident had a key and was able to lock his stand. The other resident did not have a key. -Room 2 contained two residents and 2 bedside stands, one with a lockable drawer. Neither resident had a key. -Room 3 contained two residents and 2 bedside stands each without a lockable drawer. -Room 4 contained three residents and 2 bedside stands each with a lockable drawer. None of the residents had a key. -Room 5 contained two residents and 1 bedside stand with a lockable drawer. Neither resident had a key. -Room 6 contained two residents and 2 bedside stands each with a lockable drawer. Neither resident had a key. -Room 7 contained two residents and 1 bedside stand with a lockable drawer. Neither resident had a key. -Room 8 contained one resident and 2 bedside stands each with a lockable drawer. The resident did not have a key. -Room 9 contained three residents and 3 bedside stands each with a lockable drawer. One resident had a key and was able to lock the drawer in his	D 058		

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D 058	Continued From page 4	D 058		

stand. The other residents did not have a key.
-The closets in the resident rooms had a lock in the outside doorknob (they could be opened from within without a key) but the residents did not have keys to lock them.
-The doors into the resident rooms could be locked but none of the residents had keys.

Confidential interviews on 7/27/16 through 8/1/16 with 11 residents revealed:
-At one time, they had keys and were able to lock their closets and the drawer in their bedside stands.
-The keys had been collected by two former employees and were never returned.
-The residents did not know why the keys had been collected.
-Six residents stated they did not want their money locked in the office.
-Some of the residents were hiding money in the facility to keep it safe.
-Other residents kept the money on them in their brassieres, panties, briefs and pockets of their clothing.
-A family member had purchased a locked box for one resident.
-They would like to be able to lock their closets and the drawer in the bedside stands.
-Several expressed concern about items being taken from their rooms such as snacks and drinks and it would be great if they could lock their closet doors.
-Several residents had keys and could lock the drawer in their bedside stands.
-They did not know why those residents had keys when everyone else had to turn theirs in.

Interview on 7/29/16 at 4:00pm with the Executive Director revealed:
-She worked mainly in another facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 058	Continued From page 5 -She was currently on-site training the new facility Director. -She had been told the resident's keys had been collected by previous staff. -She did not know why the keys had been taken. -She had been looking for the keys and had not found them. -She had considered buying each resident a locked box but they would be easy to carry away. -If the bedside stand drawer keys were not located, she would have the locks changed and give a key to the residents who wanted one.	D 058		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation and interviews the facility failed to assure an appropriate call system was available and operational for all residents in the facility with a current facility census of 19. The findings are: Observation on the initial tour on 7/27/16 at 10:00AM revealed no electric call bell system, no hand bells or whistles available in each of the resident rooms for each residents. Observation on 7/27/16 at 10:00AM of the	D 119		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 119	Continued From page 6	D 119		

resident in room #1 revealed:
-The resident was behind a closed door in bed with covers pulled up around shoulders.
-A highback wheelchair beside his bed.
-No call bell, hand bell or whistle was observed within reach.
-The resident was unable to verbalize if he could call staff or not.

Observation on 7/27/16 at 10:15AM of the resident in room #3 revealed:
-The resident was behind a closed door with no call bell, hand bell or whistle was observed.
-The resident was an amputee but able to transfer himself to his wheelchair.
-The roommate not in the room.
-No call bell, hand bell or whistle for roommate was observed.

Observation on 7/27/16 at 10:22AM of residents in room #5 revealed:
-Two residents were behind a closed door with no call bell, hand bell or whistle being observed. The residents were in bed and the TV was on.
- A third bed was empty.
-No call bell, hand bell or whistle for third roommate was observed.

Observation on 7/27/16 at 10:41AM of residents in room #7 revealed:
-A resident was behind a closed door with no call bell, hand bell or whistle being observed .
-The residents were in bed asleep.
- A second bed was empty.
-No call bell, hand bell or whistle for the third roommate was observed.

Observation on 7/27/16 at 10:43AM of residents in room #9 revealed:
-There were two residents at the very end of the

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 119	Continued From page 7	D 119		

hall with the door open and no call bell, hand bell or whistle being observed.
-The residents were in bed and the TV was on.
-A third and fourth bed were empty.
-No call bell, hand bell or whistle for the third or fourth bed was observed.

Confidential resident interviews conducted throughout the survey with 10 residents revealed:
-"I have no way to call staff. If I need them I would have to go get them."
-"We go get staff if we need them."
-"I would just have to wait until staff came around if I was sick and needed them."
-"its not a problem for me I can go get them if I get sick."
-"I can go get staff for my roommate if I'm in here."
-"Most people can go get a staff member but there are a few who wouldn't know what to do."
-"They couldn't hear me if I yelled."
-" I'd just have to wait on them or die, I guess."
-"I don't know what I would do."

Interview with Staff B, Supervisor-in-Charge (SIC), Medication aide, Personal care aide (PCA)on 7/29/16 at 10:15AM revealed:
- There was no call system, call bells or whistles in place.
-"We don't need one because we check on them often."
-The residents are able to come tell staff if they need them.

Interview with the Executive Director on 7/29/16 at 10:30 AM revealed:
-She was unaware the residents did not have hand bells or whistles to alert staff.
-She would go get the residents hand bells to use.

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 119	Continued From page 8 -The residents had hand bells the last time she had worked in the facility. -She verbalized the understanding of the importance of having a call system and would have staff check every 15 minutes on any resident who could not use a call system. The facility provided a Plan of Protection on 7/29/16 that included: -Check patients every 15 minutes that are unable to ask for help. -Buy hand bells and/or whistles for all patients. -Staff education on use of hand bells/whistles. -Any residents unable to use these items will have to be checked every 15 minutes. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 12, 2016.	D 119		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director (2) The activity director hired on or after July 1, 2005 shall have completed or complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. A person with a degree in recreation administration or therapeutic recreation or who is state or nationally certified as a Therapeutic Recreation Specialist or certified by the National Certification Council for Activity	D 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 129	Continued From page 9 Professionals meets this requirement as does a person who completed the activity coordinator course of 48 hours or more through a community college before July 1, 2005. This Rule is not met as evidenced by: Based on interviews and observations the facility failed to ensure the activity director completed the basic activity course within nine months of employment for assisted living activity directors. The findings are: Interview with 3 facility staff revealed: -All 3 staff knew they were responsible for the activities that were on the calendar. -All 3 staff stated the activity director created the calendar. A review of the Activity Director's personnel file revealed: -She had completed an online training program for Activity Directors, but it was not comparable based on instructional hours and content. -She had not attended the basic activity course for assisted living activity directors offered by the community colleges. -The Activity Director was not in the facility but actually worked in a sister facility in another county. Interview with the Executive Director on 7/29/16 at 10:30AM revealed: -The Activity Director came in when she needed her to but was actually located at a sister facility. -She was unaware of what type of training the Activity Director had but stated, "She told me she was an activity director and she had a certificate." -She was unaware that online activity program was not accepted by the Department. -She expected staff to provide activities on the	D 129		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 129	Continued From page 10 calendar. -She was responsible for checking the certificates.	D 129		
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 record reviews and interviews, the facility failed to assure 4 of 7 sampled staff (Staff A, D, F and G) had been tested upon employment for Tuberculosis (TB) disease in compliance with TB control measures (2-step Tuberculin skin testing) adopted by the Commission for Health Services. The findings are: A. Review of Staff A's personnel file revealed: -She had previously worked at the facility as a Personal Care Aide (PCA) and Medication Aide (MA). -Staff A was rehired on 1/4/16 as MA, Supervisor and PCA. -Step 1 of the TB skin test was completed on 10/30/14 and was negative. -Step 2 of the TB skin test was completed on	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 131	Continued From page 11	D 131		

12/12/14 and was negative.
-An unsigned notation on the TB testing record sheet stating, "Staff A does not have TB."
-There was no record of a TB skin test being completed upon rehire.

Interview on 7/29/16 at 3:20pm with Staff A revealed:
-She had not had a TB skin test upon rehire.
-The former Director had told her the TB skin tests completed in 2014 were still current and she didn't need to have another one done.

Refer to interview with the Executive Director on 7/29/16 at 4:35pm.

B. Review of Staff D's personnel file revealed:
-Staff D had been hired as a Medication Aide (MA) on 10/1/14.
-She had worked at the facility as a Personal Care Aide (PCA), Supervisor, Medication Aide (MA) and Director.
-Step 1 of the TB skin test was completed on 11/11/14 and was negative.
-Step 2 of the TB skin test was completed on 12/10/14 and was negative.

Interview on 7/29/16 at 4:35pm with the Executive Director revealed:
-She was aware 2-step TB testing was required for all new employees unless they could provide documentation of a negative TB test within the previous 12 months.
-She did not know why the former Director did not have Staff A tested for TB upon rehire.
-She did not know why Staff D had not been TB tested upon hire.
-She would call and arrange for the pharmacy nurse to complete TB skin testing for Staff A.
-All employee records would be reviewed to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 131	Continued From page 12 assure TB testing had been completed as required. -She would assure the Director-in-training followed the regulation and TB skin testing was completed as required. C. Review of Staff F's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. D. Review of Staff G's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. _____ Interview on 7/29/16 at 5:05pm with the Executive Director revealed: -Staff F and Staff G worked at another facility, within the company, a short distance up the road. -They had been covering open shifts at this facility for about 2 weeks. -The personnel files for Staff F and Staff G were at the other facility. -She was not aware copies of documents in their personnel files were required to be in any facility where they were providing care and/or administering medications. -She would copy the necessary documents for Staff F and Staff G and place them in a personnel file that would be kept at this facility.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 137	Continued From page 13 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to access the North Carolina Health Care Personnel Registry (HCPR) to assure there were no substantiated findings listed before hiring 3 of 7 sampled staff (Staff D, F and G). The findings are: A. Review of Staff D's personnel file revealed: -She had been hired on 10/1/14 as a PCA, Supervisor, MA and facility Director. -There was no documentation a HCPR inquiry being completed. Staff D was not available for interview. Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for hiring Staff D no longer worked at the facility. -Staff D currently was employed as an Activity Director within the company at another facility. -Staff E had worked at the facility for a "very long time." -She did not know why HCPR inquiries had not been completed as required for Staff D. -She was aware each of the staff should have a HCPR inquiry completed before hiring. -She would assure the Director-in-training followed the regulation and HCPR inquiries were	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 137	Continued From page 14 completed as required. B. Review of Staff F's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. C. Review of Staff G's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. _____ Interview on 7/29/16 at 5:05pm with the Executive Director revealed: -Staff F and Staff G worked at another facility, within the company,a short distance up the road. -They had been covering open shifts at this facility for about 2 weeks. -The personnel files for Staff F and Staff G were at the other facility. -She was not aware copies of documents in their personnel files were required to be in any facility where they were providing care and/or administering medications. -She would copy the necessary documents for Staff F and Staff G and place them in a personnel file that would be kept at this facility.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 139	Continued From page 15 accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct criminal background checks for 3 of 7 sampled staff (Staff A, F and G). The findings are: A. Review of Staff A's personnel file revealed: -She had previously worked at the facility as a Personal Care Aide (PCA) and Medication Aide (MA). -Staff A was rehired on 1/4/16 as a MA, Supervisor and PCA. -There was no consent for a criminal background check . -There was no documentation that a criminal background check had been completed. Interview on 7/29/16 at 3:20pm with Staff A revealed: -She had not signed a consent for a criminal background upon rehire. -The former Director had told her the criminal background check completed when she was hired in 2014 was still current and she didn't need to have another one completed. Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for hiring Staff A no longer worked at the facility -She did not know why the former Director used Staff A's previous criminal background report and did not have one completed upon rehire. -She was aware criminal background checks were to be completed for all new or re-hired staff. -She would complete a criminal background check on Staff A.	D 139		

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D 139	Continued From page 16 -She would assure the Director-in-training followed the regulation and criminal background checks were completed as required. B. Review of Staff F's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. C. Review of Staff G's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. _____ Interview on 7/29/16 at 5:05pm with the Executive Director revealed: -Staff F and Staff G worked at another facility, within the company, a short distance up the road. -They had been covering open shifts at this facility for about 2 weeks. -The personnel files for Staff F and Staff G were at the other facility. -She was not aware copies of documents in their personnel files were required to be in any facility where they were providing care and/or administering medications. -She would copy the necessary documents for Staff F and Staff G and place them in a personnel file that would be kept at this facility.	D 139		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical	D 234		

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D 234	Continued From page 17 Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the 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, North Carolina 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to test 2 of 6 sampled residents (Resident #4 and Resident #6). for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services. The findings are: A. Review of Resident #6's current FL2 dated 7/12/16 revealed: -Diagnoses included fracture history, right artificial hip joint, constipation, hyperlipidemia, Bipolar disorder, generalized anxiety, localized edema, diabetes,sleep apnea and chronic pain. -An admission date of 7/6/16. Review of Resident #6's resident record revealed: -He had been living at a skilled nursing facility. -There was no documentation of TB skin testing completed in the skilled nursing facility. -There was no documentation of TB skin testing upon admission to the facility. Refer to interview on 7/29/16 at 4:35pm with the Executive Director.	D 234		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 234	Continued From page 18 B. Review of Resident #4's current FL2 dated 6/10/16 revealed diagnoses included breast and bladder cancer, hypertension, hypothyroidism, depression, anxiety, anemia, severe obesity, ambulation dysfunction, degenerative joint disease, osteoarthritis and GERD (gastroesophageal reflux disease). Review of Resident #4's Resident Register revealed: -An admission date of 6/29/16. -The resident expired on 7/12/16. Review of Resident #4's resident record revealed: -She had been living at an independent living facility. -She had been sent to the Emergency Room and discharged to this facility. -There was no documentation of TB skin testing completed in the past. -There was no documentation of TB skin testing upon admission to the facility. Interview on 7/28/16 at 1:33pm with a staff member from the independent living facility revealed: -Resident #4 had lived at that facility for 7 years. -TB skin testing was not required upon admission to that facility. -She did not know if Resident #4 had been tested for TB in the past. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. _____ Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for assuring the	D 234		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 234	Continued From page 19 resident received TB testing upon admission no longer worked at the facility -She did not know why Resident #4 and #6 did not have documentation of TB skin testing in their records. -She was aware of the TB skin testing upon admission requirement. -She would assure the Director-in-training followed the regulation and all new admissions were tested for TB disease as required. _____ The facility provided a Plan of Protection on 9/14/16 that revealed: -Called to have TB records faxed from previous facilities thus far not received. -Will have facility physician re-administer on 8/2/16. -All patients being admitted from this day forward will have a TB test prior or at the date of admission. -Will have in place and checked upon admission and 48 hours later by the Executive Director of Director. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2016.	D 234		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Information On Home And Resident Register (b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 248	Continued From page 20	D 248		

information on the form as needed. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure a Resident Register had been completed and signed within 72 hours of admission for 2 of 6 sampled residents (Residents #4 and Resident #6).

The findings are:

A. Review of Resident #4's Resident Register revealed:
-An admission date of 6/28/16.
-All three pages were incomplete.
-The" Request For Assistance" section contained four X marks indicating unsigned spaces where the resident's, or her responsible person's, signature should have been placed.
-The "Receipt of Materials" section acknowledging the resident, or responsible person, had received information regarding the resident contract, facility house rules, Declaration of Residents' Rights, the facility's grievance procedures and the facility's willingness to comply with Title VI of Civil Rights Act had not been signed by the resident or her responsible person.
-The Discharge/Transfer section was incomplete but indicate the resident expired on 7/12/16, and had been signed and dated by the former

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D 248	Continued From page 21 Director. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. B. Review of Resident #6's Resident Register revealed: -An admission date of 7/6/16. -All three pages were incomplete. -The" Request For Assistance" section contained four X marks indicating unsigned spaces where the resident's, or her responsible person's, signature should have been placed. -The "Receipt of Materials" section acknowledging the resident, or responsible person, had received information regarding the resident contract, facility house rules, Declaration of Residents' Rights, the home's grievance procedures and the home's willingness to comply with Title VI of Civil Rights Act had not been signed by the resident of her responsible person. -The Discharge/Transfer section was incomplete but was signed and dated by the former Director. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. _____ Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for completing Residents #4 and Resident #6's admission paperwork no longer worked at the facility. -She did not know why the Resident Registers had not been completed, dated and signed by the resident or their responsible person. -She would assure the Director-in-training completed all of the required documentation when a resident was admitted to/or discharged from the facility.	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure that an initial assessment of each resident was completed within 72 hours of admission using the Resident Register for 2 of 6 sampled residents (Residents #4 and #6). The findings are: A. Review of Resident #4's Resident Register revealed: -An admission date of 6/28/16. -All three pages were incomplete. -The" Request For Assistance" section contained four X marks indicating unsigned spaces where the resident's, or her responsible person's, signature should have been placed. -The "Receipt of Materials" section acknowledging the resident, or responsible person, had received information regarding the resident contract, facility house rules, Declaration of Residents' Rights, the facility's grievance procedures and the facility's willingness to comply with Title VI of Civil Rights Act had not been signed by the resident of her responsible person. -The Discharge/Transfer section was incomplete but indicated the Resident expired on 7/12/16 and had been signed and dated by the former Director. Refer to interview on 7/29/16 at 4:35pm with the Executive Director.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 253	Continued From page 23 B. Review of Resident #6's Resident Register revealed: -An admission date of 7/6/16. -All three pages were incomplete. -The" Request For Assistance" section contained four X marks indicating unsigned spaces where the resident's, or her responsible person's, signature should have been placed. -The "Receipt of Materials" section acknowledging the Resident, or responsible person, had received information regarding the resident contract, facility house rules, Declaration of Residents' Rights, the facility's grievance procedures and the facility's willingness to comply with Title VI of Civil Rights Act had not been signed by the resident of her responsible person. -The Discharge/Transfer section was incomplete but was signed and dated by the former Director. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. _____ Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for completing Residents #4 and Resident #6 admission paperwork no longer worked at the facility. -She did not know why the Resident Registers had not been completed, dated and signed by the resident or their responsible person. -She would assure the Director-in-training completed all of the required documentation when a resident was admitted to/or discharged from the facility.	D 253		
D 317	10A NCAC 13F .0905 (d) Activities Program	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 317	Continued From page 24 10A NCAC 13F .0905 Activities Program (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 observations, interviews, and record reviews, the facility failed to assure a minimum of 14 hours of planned group activities were provided each week, that promoted socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills for the residents currently living in the facility. The findings are: Review of the July 2016 Activity Calendar revealed: -The week of July 1, 2016 through July 2, 2016 listed 4 hours of activities. -The week of July 3, 2016 through July 9, 2016 listed 15 hours of activities. -The week of July 10, 2016 through July 16, 2016 listed 15 hours of activities. -The week of July 17, 2016 through July 23, 2016	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 317	Continued From page 25 listed 15 hours of activities. -The week of July 24, 2016 through July 30, 2016 listed 15 hours of activities. Review of the July 2016 Activity Calendar for the week of 7/24/16 through 7/30/16 revealed: 7/24/26 -7-8AM Music and Coffee -10-11AM Church -3-4 nails 7/25/16 -7-8AM Music and Coffee -3-4PM Coloring 7/26/16 -7-8AM Music and Coffee -3-4PM Board games 7/27/16 -7-8AM Music and Coffee -3-4PM Crafts 7/28/16 -7-8AM Music and Coffee -3-4PM Bingo 7/29/16 -7-8AM Music and Coffee -3-4PM Movie and Popcorn 7/30/16 -7-8AM Music and Coffee -3-4PM Resident's Choice Observation on 7/26/16 at 10:15AM revealed: -No board games were offered or being played by the residents. -9 residents were in the living room with the radio on with all 9 residents sitting in chairs facing the wall where the TV was located. Observation on 7/27/16 at 3:10PM revealed no crafts were being done at this time.	D 317		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D 317	Continued From page 26 Observation on 7/28/16 at 10:22AM revealed: -ABingo game had been started in the dining room with 3 residents playing and 2 residents watching. - There was no activity noted for this time on the calendar. Observation on 7/28/16 from 3PM-4PM revealed: -There was no Bingo offered at this time as documented on the activity calendar. -There was no notice for change in times for Bingo. -There was no other activity offered in place of Bingo during this time. Confidential interviews with 5 residents revealed: -This resident had done Bingo for the residents before. -"Nobody goes by the calendar as of yet and that has been since I have been here." -"It does get boring here and I have heard other residents say they were bored." -"They don't do activities here." -"We don ' t have an activities person here, there's just not enough to do." A confidential interview with a fourth resident revealed: -"They don't have activities here." - "I wish they did." -"They don't have activities here much." - "Why do you think I'm still in the bed, I'm bored." Confidential interviews with staff members revealed: - "We are responsible to do the activities on the activity calendar." - "We do activities with the residents when we can." - "It's not the first priority personal care is." - " Staff are responsible to do the activities. "	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 317	Continued From page 27 - " I have been trained to do it all. " -If the staff can't do the activity it doesn t get done. Interview on 7/29/16 at 10:30AM with the Executive Director revealed: -Staff were expected to do the activities on the calendar. -She expected staff to do their jobs. -"I want them to focus on their personal care."	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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure that each resident has the opportunity to participate in at least one outing every other month for 6 of 6 sampled residents (#1, #2, #3, #4, #5, and #6). The findings are: On 07/27/16, interviews with the residents in the facility revealed: -The facility did not provide outings. -Three residents stated, "We don't have outings." -"We don't have outings unless we go outside and walk."	D 319		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENDERSON'S ASSISTED LIVING	602 BROOKSIDE CAMP ROAD HENDERSONVILLE, NC 28792

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D 319	Continued From page 28 -"Our family can take us out if they want." -"Other than going to the doctor or the hospital we don't go anywhere." -"We're stuck here." - "We need a van to go on outings." Observation of an activity calendar that was posted in the house for July 2016 did not include any outings. There was an activity calendar posted in the house on 8/1/16 for August 2016 did not include any outings. Interview on 7/29/16 at 10:30AM with the Executive Director revealed: -She had taken over the facility on July 17, 2016 at 5PM. -She and the new Director would be responsible for taking residents in the facility on outings. -She was unaware of any outings the previous Director had provided. -She verbalized that she understood residents were to be given the opportunity to participate in at least one outing every other month.	D 319		
D 420	10A NCAC 13F .1104(b) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (b) Upon the written authorization of the resident or his legal representative or payee, an administrator or the administrator's designee may handle the personal money for a resident, provided an accurate accounting of monies received and disbursed and the balance on hand is available upon request of the resident or his legal representative or payee.	D 420		

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D 420	Continued From page 29	D 420		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to provide an accurate accounting of the handling of personal monies for 1 of 6 sampled residents (Resident # 1).

The findings are:

Review of the current FL2 for Resident #1, dated 5/31/16, revealed diagnoses included:
-Dementia
-Seizure disorder
-Hypertension
-Malnutrition
-Orientation was noted as constantly disoriented.

Interview on 7/28/16 at 9:15am with the Executive Director (ED) revealed:
-Approximately 2 weeks ago, she had a conversation with the facility Director that caused her to be concerned about how the Director was managing a resident's account.
-The Director stated she had taken $300.00 from Resident #1's account to buy him new tennis shoes and a jogging suit.
-Resident #1's Power of Attorney (POA) was elderly and lived out of state.
-The POA had told the Director to use his funds to buy whatever he needed.
-When asked to provide the ED with the receipt for the clothing, the Director stated the left over money was in an envelope, with the receipt, in a drawer in the office but she did not give it to the ED.
-Over the next few days, the Director told the ED she had not had the time to go to the bank and deposit the remaining money.
-The ED offered to make the deposit but the Director said she would do it later.
-The Director then stated she had deposited the

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D 420	Continued From page 30 money but could not give the ED a receipt for the deposit or for the clothing. -The owner of the facility checked the resident's bank account and no deposit had been made. -The Director eventually told the ED other employees had stolen the $300.00 and 2 checks from the office. -The Director had the only key and the office should have been locked if she was not in it. -When confronted by the ED, the Director stated she would pay back the $300.00 but she only had $125.00 on her at the time. -The Director, during a telephone meeting with the facility owner and ED, agreed to pay back the $300.00, came to the facility and signed an agreement to repay the money. -The Director was terminated and reported to the Health Care Personnel Registry. -An audit of the resident accounts at multiple facilities where the Director had access to resident monies was currently in progress. -It had been determined Resident #1 was the only resident in this facility with unaccounted for funds. -The facility has not received the $300.00 from the former Director..	D 420		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 438		

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D 438	Continued From page 31	D 438		

reviews the facility failed to report a resident who had an injury of unknown origin (Resident #1) within 24 hours of each occurrence to the Health Care Personnel Registry (HCPR).

The findings are:

Observation of Resident #1 on initial tour of the survey on 7/27/16 at 10:00AM revealed he was behind a closed door in a dark room, lying in bed with covers up around his shoulders.

Observation of Resident #1 on 7/28/16 at 11:50 AM revealed Resident #1 had a cast on his left hand/arm.

Review of current FL2 for Resident #1, dated 5/31/16, revealed diagnoses which included:
-Dementia, Seizure disorder, Hypertension, Malnutrition.
Orientation for Resident #1 was noted as constantly disoriented.

Review of Resident #1's Care Plan revealed:
-He required extensive assist with eating, ambulation, and transferring.
-He required total assistance toileting, bathing, dressing, grooming.

Review of Resident #1's medical record revealed:
- A physician order on 7/12/16 read "Please have mobile x-ray perform portable x-ray of left hand."
-"Diagnosis: hand pain/contusion. (Can be done on 7/12 or 7/13)."
-The order was signed by the facility physician.

Further review of the medical revealed no other documentation of Resident #1's left hand injury.

Review of Resident #1's radiological impression

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D 438	Continued From page 32	D 438		

dated 7/14/16 revealed:
-An x-ray of Resident #1's left hand with 3 views completed 7/14/16.
-Impression was a spiral fracture of the fifth metacarpal neck.

Interview of Resident #1 on 7/28/16 at 11:50AM revealed:
-Resident #1 could not say how his left hand/arm got hurt.

Interview on 7/28/16 at 12:05PM with Staff A, Medication Aide revealed she was not sure how Resident #1 had hurt his hand but did know that the resident had received treatment for it.

Interview on 7/28/16 at 2:14PM with Staff F, Personal Care Assistant (PCA) revealed:
-She was not sure how Resident #1 had hurt his left hand.
-Resident #1 had seizures but she was unaware if he had one related to the incident where his hand was injured.

Interview on 7/29/16 at 8:45AM with Resident #1's Roommate revealed:
-He was unaware of how Resident #1's hand was injured.
-He remembered him complaining of it being painful afterwards.

Interview on 7/28/16 at 3:30PM with the Executive Director revealed:
There was no Incident and Accident report for Resident #1's painful hand.
-She was unaware of how Resident #1's hand was hurt.
-She did not file an incident report after discussing it with facility physician, as they (ED and physician by report) did not feel it was an

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D 438	Continued From page 33 incident. -She had talked to her staff about Resident#1's hand when she first took over the facility. -She reported her staff were unaware of how Resident #1's hand was injured. -She had called Resident#1's family. -She had notified facility physician and he ordered for Resident #1 to be taken to Urgent Care. -She made sure he had received needed medical care but did not notify HCPR.	D 438		
D 447	10A NCAC 13F .1210 Record Of Staff Qualifications 10A NCAC 13F .1210 Record Of Staff Qualifications An adult care home shall maintain records of staff qualifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain records of staff qualifications for 5 of 7 sampled staff (Staff A, B, D, F and G). The findings are: A. Review of Staff A's personnel file revealed: -She had previously worked at the facility as a Personal Care Aide (PCA) and Medication Aide (MA). -She was rehired on 1/4/16 as PCA, MA and	D 447		

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D 447	Continued From page 34 Supervisor . -There was no documentation TB skin testing had been done. -There was no documentation a criminal background check had been done. -There was no documentation of a controlled substance screen/exam upon rehire. -There was documentation of completion of the "CPR On Line" program which was not training recognized by the Division. -The clinical skills validation prior to administering medications had not been completed. -There was no documentation of a Licensed Health Professional Support (LHPS) task competency evaluation upon or since rehire. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. B. Review of Staff B's personnel file revealed: -She had been hired 10/27/14 as a Personal Care Aide (PCA) and Medication Aide (MA). -No documentation of current CPR certification. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. C. Review of Staff D's personnel file revealed: -She had been hired on 10/1/14 as a MA, Supervisor and the (facility) Director. -There was no documentation a North Carolina Health Care Personnel Registry (HCPR) check had been completed. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. _____ Interview on 7/29/16 at 4:35pm with the Executive Director revealed:	D 447		

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D 447	Continued From page 35 -The Director responsible for hiring Staff A, B and D no longer worked at the facility -She did not know why the former Director had not completed the required documentation for staff upon hire. -The staff files would be audited for compliance. -She would assure the Director-in-training completed the required documentation for staff at the time of hire. D. Review of Staff F's personnel file revealed the facility did not have a copy of her qualifications in the facility. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. E. Review of Staff G's personnel file revealed the facility did not have a copy of her qualifications in the home. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. _____ Interview on 7/29/16 at 5:05pm with the Executive Director revealed: -This facility was not part of a cluster of licensed facilities. -Staff F and Staff G worked at another facility, within the company, a short distance up the road. -They had been covering open shifts at this facility for about 2 weeks. -The personnel files for Staff F and Staff G were at the other facility. -She was not aware copies of documents in their personnel files were to be maintained in this facility. -She would copy the necessary documents for Staff F and Staff G and place them in personnel	D 447		

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D 447	Continued From page 36 files that would be kept at this facility.	D 447		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to treat residents with respect, dignity and full recognition of his or her indiviuality and the right to privacy related to the common bathroom door remaining open when a resident (Resident #6) in a wheelchair needed to use the bathroom. The findings are: A review of the current FL2 for Resident #6 dated 7/12/16 revealed: -Diagnosis included hip fracture, right artificial hip joint, diabetes, edema and chronic pain. Observation on 7/28/16 at 11:50AM of the common bathroom in the main hallway beside the dining room and living room revealed: -Resident #6 using the bathroom with the door open and the resident's wheelchair blocking the door from closing. -There was 4 residents and 1 staff member in the living room. General Observations of the common bathroom throughout the survey revealed residents with walkers had to leave their walkers outside the	D911		

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D911	Continued From page 37 bathroom door in order to close the bathroom door for privacy. Further observation of the common bathroom revealed: -The bathroom door was 6 steps away from the dining room and living room areas. -The bathroom door width measured 29 inches. The bathroom measured 38 inches from the door to the commode seat. Interview on 7/28/16 at 4:05PM with Resident #6 revealed: -He was unable to use the bathroom and close the door. -He could not transfer from his wheelchair at the bathroom door and then ambulate to the toilet closing the door. -He was fearful of falling. -He was "humiliated" having to use the bathroom with the door open. -He did not like living at the facility because of this. -He had told the previous Director when he first arrived of his feelings and concern about having to leave the bathroom door open, "but nothing was done." -He had to roll himself to his room at the very end of the hall to wash his hands because it's too hard to move his chair back away from the sink in order to be able to wash his hands. -He had talked to his Guardian about the bathroom situation and his concerns. Interview with Resident #6's Guardian on 7/29/16 at 3:59PM revealed: -She had visited Resident #6 on the second day after his admission. -Resident #6 had 2 hip fractures prior to his moving in to the facility.	D911		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D911	Continued From page 38 -She had concerns about his ability to use the bathroom with the door open. -She spoke to the Director at the time who was reported as looking into it for a solution. -She confirmed he had shared with her that his situation was "humiliating". Interview with Staff F personal care aide (PCA) on revealed: -She was aware residents with walkers had to leave them outside common bathroom in order to close the door. -She was unaware of any residents leaving the door open to go to the bathroom. Interview with Staff B, medication aide on 7/29/16 at 10:15AM revealed: -"The bathrooms are small." -Residents leave there walkers or wheelchairs outside of the bathroom in order to close the door. -She was unaware of any residents leaving the door open to go to the bathroom. Interview with the Executive Director on 8/1/16 at 11:10AM revealed: -She had observed a female resident using the common bathroom with the door open. -She assisted the resident with closing the door. -She was unaware of any other residents using the bathroom with the door open. -She expected the staff to assist residents to the bathroom. -"I like for them (staff) to take them to the bathroom." -"They shouldn't have to leave the bathroom door open."	D911		

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D934	Continued From page 39	D934		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 4 of 6 sampled Medication Aides (Staff D, E, F, and G) had received the mandatory annual state training on infection control, safe practices for injections, and glucose monitoring. The findings are: A. Review of Staff D's personnel file revealed: -She had been hired on 10/1/14 as a Medication Aide (MA). -There was a certificate documenting the state infection control training had been completed on 5/26/15. Refer to interview on 7/29/16 at 4:35pm with the Executive Director.	D934		

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D934	Continued From page 40 B. Review of Staff E's personnel file revealed: -She had been hired on 1/16/98 as a MA. -There was a certificate documenting state infection control training had been completed on on 5/1/15. Refer to interview on 7/29/16 at 4:35pm with the Executive Director. _____ Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for hiring Staff D and E no longer worked at the facility -She did not know why the former Director had not assured Staff Dcompleted the required documentation for staff upon hire. -The staff files would be audited for compliance. -She would contact the pharmacy nurse and schedule training at his earliest convenience. -She would assure the Director-in-training scheduled training to meet the regulation requirements. C. Review of Staff F's personnel file revealed the facility did not have a copy of her qualifications in the facility. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. D. Review of Staff G's personnel file revealed the facility did not have a copy of her qualifications in the home. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. _____	D934		

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D934	Continued From page 41 Interview on 7/29/16 at 5:05pm with the Executive Director revealed: -Staff F and Staff G worked "up the road at another facility in the company." -They had been covering open shifts at this facility for about 2 weeks. -The personnel files for Staff F and Staff G were at the other facility. -She was not aware if their infection control training was current. -She would copy the necessary documents for Staff F and Staff G and place them in personnel files that would be kept at this facility.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.	D935		

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	HAL045113	A. BUILDING: _____ B. WING _____	08/01/2016

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D935	Continued From page 42 (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 3 of 6 sampled Medication Aides (Staff A, F and G) had successfully completed the clinical skills validation portion of the competency evaluation prior to the administration of medications and 4 of 6 sampled Medication Aides (Staff D, E, F, and G) had successfully passed the written Medication Aide examination within 60 days after successful completion of the clinical skills validation portion of a medication administration competency evaluation. The findings are: A. Review of Staff A's personnel file revealed:	D935		

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D935	Continued From page 43 -She had previously worked at the facility as a Personal Care Aide (PCA) and Medication Aide (MA). -Staff A was rehired on 1/4/16 as a Medication Aide (MA), Supervisor and Personal Care Aide (PCA). -The medication clinical skills validation form was dated 4/30/15. Interview on 7/29/16 at 3:20pm with Staff A revealed: -She had not had the medication clinical skills validation with the pharmacy nurse since she had been rehired. -She had been administering medications to the residents since 1/4/16. -The former Director had told her the clinical skills validation form from 4/30/15 was still current and she didn't need to have another one completed. Refer to interview with the Executive Director on 7/29/16 at 4:35pm. B. Review of Staff D's personnel file revealed: -She had been hired on 10/1/14 as a Medication Aide (MA), Supervisor and Personal Care Aide (PCA) and (facility) Director. -She had completed the medication clinical skills validation on 10/1/14. -She had passed the written examination on 2/5/15. Refer to interview with the facility Administrator on 7/29/16 at 4:35pm. C. Review of Staff E's personnel file revealed: -She had been hired on 1/16/98 as a Personal Care Aide (PCA). -She had completed the medication clinical skills validation on 4/00 (Only the month and year had	D935		

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D935	Continued From page 44 been documented.) -She had passed the written examination on 12/5/00. Refer to interview with the Executive Director on 7/29/16 at 4:35pm. _____ Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for hiring Staff A no longer worked at the facility -She did not know why the former Director used Staff A's old checklist and did not have the pharmacy nurse validate her skills upon rehire. -She was aware clinical skills validation had to be successfully completed on new and rehired Medication Aides prior to the administration of medication to the residents. -She would call and arrange for the pharmacy nurse to complete the clinical skills validation for Staff A. -She would assure the Director-in-training followed the regulation and all MA's had successfully completed the clinical skills validation portion of the competency evaluation prior to the administration of medications. -Staff D was currently employed as an Activity Director within the company at another facility. -The Director responsible for hiring Staff D no longer worked at the facility. -Staff E had worked at the facility for a "very long time." -She was aware MAs had to pass the written examination within 60 days after successful completion of the clinical skills validation. -She did not know why Staff D and Staff E did not take their written test within the allotted 60 days. -She would assure the Director-in-training	D935		

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D935	Continued From page 45 followed the regulation and MA's were tested within the allotted 60 days. D. Review of Staff F's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. C. Review of Staff G's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. _____ Interview on 7/29/16 at 5:05pm with the Executive Director revealed: -She worked mainly in another facility, within the company, a short distance up the road. -She was currently on-site training the new facility Director. -Staff F and Staff G worked at the another facility, within the company, a short distance up the road. -They had been covering open shifts at this facility for about 2 weeks. -The personnel files for Staff F and Staff G were at the other facility. -She was not aware copies of documents in their personnel files were required to be in any facility where they were providing care and/or administering medications. -She would copy the necessary documents for Staff F and Staff G and place them in personnel files that would be kept at this facility.	D935		

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D992	Continued From page 46	D992		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.	D992		

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D992	Continued From page 47 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure an examination and screening for controlled substances was performed for 3 of 7 sampled staff (Staff A F, and G) hired after 10/1/13. The findings are: A. Review of Staff A's personnel file revealed: -She had previously worked at the facility as a Personal Care Aide (PCA) and Medication Aide (MA). -Staff A had been rehired on 1/4/16 as a PCA, MA and Supervisor. -Documentation of testing for controlled substances performed on 11/3/14, prior to her previous employment. -No documentation screening for controlled substances had been performed prior to rehire. Interview on 7/29/16 at 4:35pm with the Executive Director revealed: -The Director responsible for hiring Staff A no longer worked at the facility -She did not know why the former Director used Staff A's previous screening for controlled substances report and did not have one completed upon rehire. -She was aware screening for controlled substances was to be performed for all new or re-hired staff. -She would perform a screening for controlled substances for Staff A. -She would assure the Director-in-training followed the regulation and performed a screening for controlled substances as required.	D992		

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D992	Continued From page 48 B. Review of Staff F's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. C. Review of Staff G's personnel file revealed there were no documents in the facility regarding this staff member. Refer to interview on 7/29/16 at 5:05pm with the Executive Director. _____ Interview on 7/29/16 at 5:05pm with the Executive Director revealed: -Staff F and Staff G worked at another facility, within the company, a short distance up the road. -They had been covering open shifts at this facility for about 2 weeks. -The personnel files for Staff F and Staff G were at the other facility. -She was not aware copies of documents in their personnel files were required to be in any facility where they were providing care and/or administering medications. -She would copy the necessary documents for Staff F and Staff G and place them in a personnel file that would be kept at this facility.	D992		