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	HAL086001	A. BUILDING: _____ B. WING _____	R 01/06/2017

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CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

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D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted an annual and follow-up survey on January 5-6, 2017.	D 000		
D 034	10A NCAC 13F .0302 (f) Design And Construction 10A NCAC 13F .0302 Design And Construction (f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review This Rule is not met as evidenced by: Based on interviews, observations and record reviews the facility failed to assure a current fire inspection report was maintained in the facility at all times. The findings are: Review of the facility's current fire inspection report dated 4/13/15 revealed "need to see boiler certification". Interview on 1/5/17 at 10:45am with the Administrator revealed: -The most current fire inspection was on 4/13/15. -"The fire inspector comes without us having to call him." -He will call the fire inspector and have them come out today. -He had not realized the fire inspection was due and out of date. -He had never known of the facility having to notify the fire inspector for an inspection.	D 034		

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D 034	Continued From page 1 -The previous Administrator, may have contacted them, but he was not for sure. Interview on 1/5/16 at 12:10pm with the Fire Inspector revealed: -He had been called "this morning" by the facility Administrator to do a fire inspection. -"We are short an inspector, and have a lot of facilities in our county." -"We don't have a schedule of when each facility fire inspection is due." -"We depend on the facility to let us know when their inspection is due." Review of a second fire inspection report dated 1/5/17 revealed "hood system needs inspection, employee training on fire extinguishers, employee training documentation".	D 034		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to replace broken and missing slats from vertical window blinds in 14 of 16 occupied resident rooms, 2 of 2 common bathrooms with windows and the common living room. The findings are:	D 083		

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D 083	Continued From page 2 Observation on 01/05/17 at 9:07AM of Resident Room A-7 revealed: -The occupant was not in the room. -A slat from vertical window blinds was missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. Observation on 01/05/17 at 9:10AM of the Common Bathroom between Resident Rooms A-5 and A-6 revealed: -Two slats from vertical window blinds were missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. -In a direct line of vision from the window was a toilet. Observation on 01/05/17 at 9:14AM of Resident Room A-5 revealed: -The occupant was laying in her bed but she did not want to talk. -Slats from vertical window blinds were missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. Interview on 01/05/17 at 9:14AM with the occupant of Resident Room A-5 was attempted and unsucessful. Observation on 01/05/17 at 9:16AM of Resident Room A-8 revealed: -The occupant was present in the room. -Slats from vertical blinds were missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside.	D 083		

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D 083	Continued From page 3 Interview on 01/05/17 at 9:16AM with the Occupant of Resident Room A-8 revealed: -"People don't look in [my room]" and lights from cars on the road did not affect his sleep. -He was not bothered by the missing slats from the vertical window blinds and was not sure if they had been reported to Maintenance staff. Observation on 01/05/17 at 9:45AM of Resident Room A-12 revealed: -Three beds in the room. -One of the occupants was lying down with their eyes closed,the second occupant was awake but his speech was incoherent and the third occupant was not present (based on observation it was determined the second occupant in Resident Room A-12 was not interviewable). -Slats from vertical window blinds were missing, resulting in two distinct gaps which, when the blinds were closed, permitted unobstructed vision from outside to inside. Observation on 01/05/17 at 10:01AM of the Common Living Room revealed: -Three windows, all with vertical window blinds. -Slats were missing in all three windows. Observation on 01/06/17 at 6:50AM of Resident Room B-14 revealed: -Two occupants were lying in their beds with their eyes closed. -Two slats from vertical window blinds were missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. Observation on 01/06/17 at 6:51AM of Resident Room B-24 revealed: -Two occupants were lying in their beds with their eyes closed.	D 083		

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D 083	Continued From page 4 -Six slats from vertical window blinds were missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. Observation on 01/06/17 at 6:52AM of Resident Room B-13 revealed: -An occupant awake and in the room. -Numerous slats from vertical window blinds were missing, resulting in an approximately 2 foot gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. Interview on 01/06/17 at 6:52AM of the occupant of Resident Room B-13 revealed "privacy is important to me" but she did not tell anyone about the gap in her vertical window blinds. Observation on 01/06/17 at 6:53AM of Resident Room B-25 revealed: -No occupants were present in the room. -Nine slats from vertical window blinds were missing resulting in an approximately 1 ½ foot gap. -Two curtain panels were hanging over the vertical blinds, covering up a portion of the gap resulting from the missing slats but leaving approximately a 6 inch gap which, when the blinds were closed and curtain panels were fully opened up, permitted unobstructed vision from outside to inside. Observation on 01/06/17 at 6:55AM of Resident Room A-11 revealed: -The occupant was present in the room. -Missing slats from vertical window blinds were missing, resulting in an approximately 2 foot gap which, when the blinds were closed and curtain panels were fully opened up, permitted unobstructed vision from outside to inside.	D 083		

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D 083	Continued From page 5 Interview on 01/06/17 at 6:55AM of the occupant of Resident Room A-11 revealed: -The missing slats "doesn't make much difference to me." -"Sometimes I like to watch traffic" on the road outside the window. Observation on 01/06/17 at 7:00AM of Resident Room A-9 revealed: -The occupant was present. -A blanket covering closed vertical window blinds. -Pulling back the blanket exposed a missing slat from the vertical blinds. Interview on 01/06/17 at 7:00AM of the occupant of Resident Room A-9 revealed: -He had hung the blanket over the gap in the vertical blinds "so nobody could see in." -"Privacy is important to me." -He had never asked any staff member to replace the missing slat but "that would be nice if they would fix it." Observation on 01/06/17 at 7:05AM of Resident Room A-4 revealed: -Both occupants were present. -13 slats from the vertical window blinds were missing, resulting in most of the window not being covered when the blinds were pulled closed. Interview on 01/06/17 at 7:05AM with the occupants of Resident Room A-4 revealed: -The condition of the window blinds had been that way for "awhile" and neither occupant had asked anyone to fix them. -One of the occupants stated "you can't change your clothes." -One of the occupants stated that privacy was important to him.	D 083		

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D 083	Continued From page 6 -One of the occupants stated "a fellow waved at us" as he could see them through the window into the room. -One of the occupants "would feel more comfortable" if the blinds were fixed. -One of the occupants stated that if fixed and closed in the summer, the blinds would "keep the sun from shining" into the room. Observation on 01/06/17 at 7:10AM of Resident Room A-3 revealed: -The occupant was not present. -Four slats from vertical window blinds were missing, resulting in an approximately 1 foot gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. Observation on 01/06/17 at 7:10AM of the Common Bathroom between Resident Rooms A-2 and A-3 revealed: -One slat from vertical window blinds was missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. -In a direct line of vision from the window was a toilet and a bathtub. Observation on 01/06/17 at 7:15AM of Resident Room A-2 revealed: -An occupant was present. -One missing slat and two broken slats (both propped up in place on the window sill) from vertical window blinds, resulting in gaps which, when the blinds were closed, permitted unobstructed vision from outside to inside. Interview on 01/06/17 at 7:15AM of the occupant of Resident Room A-2 revealed: -He had never asked any staff member to fix the blinds.	D 083		

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D 083	Continued From page 7 -He wanted to have the blinds fixed to have some privacy. -He had never seen people looking into his room but they do walk outside by their cars. Observation on 01/06/17 at 7:20AM of Resident Room A-1 revealed: -One occupant who was lying in bed with their eyes closed. -Two slats from vertical window blinds were missing, resulting in a gap which, when the blinds were closed, permitted unobstructed vision from outside to inside. Interview on 01/06/17 at 7:40AM of the Housekeeper/Maintenance staff revealed: -He was responsible for housekeeping and maintenance issues in the facility. -He had not received any complaints from residents regarding missing slats from vertical window blinds. -Staff had told him they thought the blinds were "ugly" but they had never reported anything about missing slats. -He was aware of broken slats in some of the blinds, especially Resident Room A-4 where when the blinds are closed one can "see out through half the window." -He thought blinds should be in good repair and work. -He had never seen residents outside looking through windows.	D 083		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on	D 164		

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D 164	Continued From page 8 the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure that training on the care of diabetic residents was provided to 2 of 3 sampled staff who administer medications (A, B) prior to the administration of insulin to residents. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired as a Medication Aide on 5/12/16. -She passed the medication aide test on 3/4/13. -She had worked previously as a Medication Aide at another facility. -There was no documentation of diabetic care	D 164		

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D 164	Continued From page 9 training for Staff A. Interview with Staff A on 1/6/17 at 9:30am revealed: -She had diabetic training at the previous facility she worked at as a Medication Aide. -She had been trained at the previous facility in the types of insulin, how to store it, how to inject insulin, the signs and symptoms hypoglycemia and hyperglycemia. -She verbalized to the surveyor how to determine and administer sliding scale insulin. Refer to interview on 1/6/17 at 10:45am with the Resident Care Coordinator. 2. Review of Staff B's personnel file revealed: -Staff B was hired as a Medication Aide on 6/14/16. -She passed the medication aide test on 7/28/16. -There was no documentation of diabetic care training for Staff B. on 1/6/17 Staff B was not available for interview. Refer to interview on 1/6/17 at 10:45am with the Resident Care Coordinator. Interview on 1/6/17 at 11:25am with the Administrator revealed the Resident Care Coordinator was responsible for staff training. --- Interview on 1/6/17 at 10:45am with the Resident Care Coordinator revealed: -When the LHPS Nurse (Licensed Health Professional Support) does the medication validation she covers diabetic care. -She was under the impression that the LHPS	D 164		

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D 164	Continued From page 10 medication validation was the diabetic training. -"This had never been an issue with previous surveys." -The facility does not do "specific" diabetic training.	D 164		
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 observations, interviews and record reviews, the facility failed to assure 2 of 2 Staff (A, B) who administer diabetic care completed annual state infection control training. The findings are: 1. Review of Staff A's personnel file revealed: -Staff A was hired as a Medication Aide on 5/12/16. -She had worked previously as a Medication Aide	D934		

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D934	Continued From page 11	D934		

at another facility.
-No infection control training had be done with Staff A at the facility since she was hired.
-There was no documentation of state infection control training.

Interview with Staff A on 1/6/17 at 9:30am revealed she had the state infection control training at the previous facility where she worked at as a Medication Aide.

Refer to interview on 1/6/17 at 10:45am with the Resident Care Coordinator.

2. Review of Staff B's personnel file revealed:
-Staff B was hired as a Medication Aide on 6/14/16.
-No infection control training had be done with Staff A at the facility since their hire.
-There was no documentation of state infection control training.

Staff B was not available for interview.

Refer to interview on 1/6/17 at 10:45am with the Resident Care Coordinator.

Interview on 1/6/17 at 11:25am with the Administrator revealed the Resident Care Coordinator was responsible for the staff training.

Interview on 1/6/17 at 10:45am with the Resident Care Coordinator revealed:
-The annual infection control training is done in June of each year.
-The facility did not do any initial infection control training with medication aides because "previous surveyors" told her it was "useless and did not

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D934	Continued From page 12 count as required training." -She had contacted the LHPS Nurse (Licensed Health Professional Support) and the infection control training was going to be done on 1/30/17 with anyone who needed it.	D934		