

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28841		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Burke County Department of Social Services conducted a complaint investigation on December 5 - 7, 2016 with an exit conference via telephone on December 12, 2016. The complaint investigation was initiated by the Burke County Department of Social Services on October 21, 2016.	D 000	Response Preface: The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that the stated deficiencies are accurate.	
D 320	10A NCAC 13F .0905 (g) Activities Program 10A NCAC 13F .0905 Activities Program (g) Each resident shall have the opportunity to participate in meaningful work-type and volunteer service activities in the home or in the community, but participation shall be on an entirely voluntary basis, never forced upon residents and not assigned in place of staff. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to prevent 5 of 10 residents (Residents #3, #4, #6, #7 and #10) from working an excessive number of hours and to properly assess impact on on pre-existing health conditions as participants of a volunteer work program, predominantly performing tasks which would have otherwise been performed by paid employees. The findings are: A. Review of Resident #8's current FL-2 dated 3/11/16 revealed:	D 320	The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina, or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. 10A NCAC 13F .0905 (g) Activities Program - The Worker Bee Program was cancelled in its entirety, indefinitely. - The Administrator will meet with all residents and staff to make sure they understand that we no longer are offering the Worker Bee Program and to discuss any concerns. - All Worker Bee work projects will be completed by the current staff by the already staffed and responsible departments.	1/16/17 1/17/17 1/16/17

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

L. R. [Signature] President

1-26-17

STATE FORM

6899

8YXP11

(If continuation sheet 1 of 44)

Plan of Correction reviewed and accepted. [Signature]
Nurse Cass [Signature] I
2/3/17

Division of Health Service Regulation

UNOFFICIAL COPY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 1 -Diagnoses included chronic obstructive pulmonary disease, seizure disorder and history of schizophrenia with anxiety attacks. -The resident was documented as being self-ambulatory with use of a wheelchair as needed. Review of Resident #6's Resident Register revealed: -An admission date of 03/31/15. -The resident was her own responsible person. Review of Resident #6's Annual Activity Review dated 08/08/16 revealed: - "Physical Restrictions" were documented as "both feet are hurting most of the time." - "Work Type/Volunteer" were documented as "Participates in 'worker bee' program." - "Comments" were documented as "Does a great job in 'worker bee' program." -The Review was signed and dated by the Activity Coordinator. Review of a Plan of Service Summary for Resident #6 dated 09/20/16 revealed: -Activities of Daily Living (ADLs) assistance level ranged from limited to extensive. -The activity of "On-site Laundry Tasks" was documented with a frequency of two days/week and as requiring extensive assistance. -The Summary was signed and dated by the resident with the printed name of the facility owner. Review of Resident #6's printed charting notes from the computerized record revealed: -An entry dated 08/09/16 that the resident had received bilateral knee corticosteroid injections with follow up in four months. -No entries during the review period of 07/19/16	D 320	- If the community decides to ever implement any work-type activities in the future the following language has been recommended for use in the program; however, the community is not planning to offer any such program at this time. "A resident may only work or provides services at the facility if the following requirements are met: 1. The resident's primary care provider has determined that the resident can safely perform the services; 2. The facility documents the need or desire for work in the resident's plan of care; 3. The plan of care specifies the nature of the services performed and whether the services are voluntary or paid. Participation in any volunteer or compensated work or services shall be on an entirely voluntary basis, never forced upon the resident, and not assigned in place of staff. The resident may always refuse to perform services for the facility; and 4. If compensation is paid for services, the pay must be at or above prevailing rates (including any subminimum wage approved by the Department of Labor) and the resident must agree to the work arrangement described in the resident's plan of care." - All residents interested in work-type activities will be referred by the Administrator to available resources in the community. If no resources are available we will contact the Department of Health Service Regulation or local Department of Social Services for advice on other available programs. G.S. 131D-21(4) Declaration of Residents' Rights - See the POA outlined above.	TBD 1/16/17 - On-going

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 2 through 12/03/16 concerning participation in the volunteer worker program. Review of Resident #6's Worker Bee Volunteer Agreement and Waiver dated 03/06/14 revealed: -The resident's signature and the signature of the Activity Coordinator. -Attached to the Agreement and Waiver was a Volunteer Statement with the resident's and Activity Coordinator's signatures, also dated 03/06/14. Review of Resident #6's "Worker Bee Volunteer-Position Description" form revised on 01/28/14 revealed: -A position title of "Laundry" (the phrase "Assist in cleaning dining room" was crossed out). -Nothing documented for "Purpose." - "Responsibilities" was documented as assistance with laundry. - "Supervisor" was documented with the names of the administrator and unknown staff person. - "Schedule" was documented as "laundry as needed." - "Benefits" were documented as "Encourage use of their industrial skills and abilities in order to promote well-being and facilitate therapeutic use of mind & body." -Nothing documented for "Support Provided". -Handwritten in the lower margin of the form was "Laundry only!" with the initials of the Activity Coordinator. Review of Resident #6's printed Volunteer Statement with the heading of "Work Type Activity Program" revealed the resident's signature, the signature of the Activity Coordinator and the date 03/06/14. Observation on 12/05/16 at 4:00PM of Resident	D 320			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 3 #6 revealed the resident pushing a cart of dirty laundry in the hallway. Interview on 12/05/16 at 4:00PM of Resident #6 revealed she was "doing laundry." Interview on 12/06/16 at 9:25AM with Resident #6 revealed: - "I get confused" and she had "short term memory issues." - She was familiar with the "Worker Bee" program and worked in the laundry. - She used to work in the kitchen and dining room, but only washed dishes for a short period of time and at the same time did laundry. - She had to stop working in the kitchen due to a foot problem. - It was hard for her to count the number of hours she did laundry as "I come and go." - Some days doing laundry were busier than others, with Sunday as slow as there were no resident baths, therefore no towels to wash. - She tried to start laundry before 7:00AM and tried to get it done "a little after supper." - The carts used for dirty laundry were "broken up" and the wheels were "terrible" with one cart having a missing wheel for 2 to 3 months, which she told the Resident Care Coordinator (RCC) and "I think [Administrator]." - Another cart's wheels would not spin in the right direction which required "fighting gravity with bad knee," mostly, her left knee. - She pushed the dirty laundry carts to the laundry room. - She washed "pretty much everything" but did not wash clothing for one named resident. - She did some resident's personal laundry in the room with a household washer and dryer, and the rest of the laundry in a "big wash" in a room with a commercial washer and dryer.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 4 -She did "private wash" for a few residents and did so without pay, so long as the residents provided her with laundry detergent. -Towels, sheets, incontinence pads and residents clothing were washed in a commercial washer and dryer. -If she came across unlabeled clothing, she notified the Activity Coordinator to find the rightful owner. -If soiled linens were "really, really bad," staff were expected to address it. -Of late, there had been no staff doing laundry but "they used to" do it and "they really did not have to" do it. -She washed soiled and urine-soaked linens but she wore gloves. -Laundry detergent was dispensed automatically and directly into the washer, based on the articles being washed and "I know how to push buttons" on the automatic dispenser. -She dried and folded clean clothes and linens. -She did not feel overwhelmed in performing the laundry tasks. -The laundry tasks were "definitely volunteer" and they "keep my mind busy." -"I get bored, I need to do something." -"Normal pay" was once \$30 a week, but it was increased to \$45 a week as "it is a two person job." -"A while back" there was a second resident helping with laundry but they were not much help, so the second person was no longer helping. -She was not aware of staff doing laundry on evening or night shifts. -"Occasionally" there were laundry complaints from residents about a missing article of clothing, but the door to the laundry room was locked and the Administrator had told her to bring these complaints to her attention.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

JONAS RIDGE ADULT CARE

**9051 HWY 181
JONAS RIDGE, NC 28641**

(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 320	Continued From page 5 Observation on 12/06/16 at 9:45AM of the dirty laundry cart located in the hallway across from Resident #6's room revealed a missing wheel in which prevented ease of movement. Observation on 12/06/16 at 9:50AM of Resident #6 revealed her independently walking in the hallway without an ambulatory aide but with a slight limp, periodically grabbing the hallway handrails. Observation on 12/06/16 at 9:50AM of the room with the household washer and dryer with Resident #6 present revealed: -A load of wash in the front-loading washer. -A missing wheel on a second dirty laundry cart located in the room. Observation on 12/06/16 at 9:52 AM of the room with the commercial washer and dryer with Resident #6 present revealed: -The door was locked with a door handle/push button lock combination set. -Resident #6 punched in the code and the door unlocked. -A load of pads in the front-loading washer. -A load of sheets in the front-loading dryer. -An automatic detergent dispensing system. -Three 33 gallon plastic trash cans with lids. A second interview on 12/06/16 at 9:52AM with Resident #6 revealed: -She had put the load of laundry into the front-loading household washer. -The second dirty laundry cart moved a "bit better" than the one in the hallway across from her room. -She had put the laundry in the commercial washer and dryer. -A technician from the vendor supplying the	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 6 laundry detergent came once a month to check the automatic dispenser and for supply of product. -The three trash cans were for dirty pads, colors and whites. -She did not clean the inside of the trash cans. -She did clean the dryer of lint between loads. -"In the beginning" of working the laundry, she was shown how to use the washer and dryer. -If she were no longer paid to complete the laundry task, "I would have to consider" whether or not to continue working in the laundry and "I would have to think about it." Interview on 12/06/16 at 3:10PM with the Activity Coordinator revealed: -She had been the Activity Coordinator since 2013, when the current Owner assumed management responsibilities. -The Owner brought to the facility the "Worker Bee" program from another facility with a list of positions that residents could work. -Both she and the Administrator managed the program, including making job changes. -If residents in the program work the program, they were paid every Wednesday in cash, with the amount prorated for days missed. -The Administrator wrote a check from an account for this purpose, cashed it and the money was disbursed. -Previously the residents were paid a "little more," "a fair amount," but she and the Administrator were told to "cut back" by the Owner. -Resident #6 did not get compensated enough for doing laundry. -Resident #6 was reluctant to leave the facility on outings and felt an "obligation" due to her laundry tasks. -Before the program was implemented, existing employees did laundry and had lots of	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 7 complaints. -Resident #6 had knee, feet and hand problems, but the attending Nurse Practitioner was aware of her participation in the program. -Resident #6 would seldom take advice when her knees hurt and she needed to take a break. -To relieve pressure off her feet, Resident #6 would use her wheelchair more. -Resident #6 had been doing laundry tasks for at least a year. -If Resident #6 was not able or permitted to do the laundry, the Owner would be "forced" to hire someone or laundry would pile up. -Current PCA staffing could not absorb the laundry tasks. -A lot of employed staff "come and go." -Any resident assessments done for the program were not put into writing, but she and the Administrator had talked about the residents' abilities to do the tasks. -There were no records kept of how many hours of work each resident in the program completed for their tasks. -She thought Resident #6 was "replacing an employee." -Residents have asked her to find them something to do to "make some money." -No employees were let go for these tasks to have them replaced with and be done by residents. Interview on 12/06/16 at 3:45PM with the Administrator revealed: -The Owner had a problem at another facility with a volunteer program and the Agreement was created, with review "at the State level." -The resident or Guardian was required to sign the Agreement. -She, the Activity Coordinator and the Department Heads provided oversight for the program.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 8 -There was no documentation available regarding resident performance at assigned tasks. -There was no documentation available regarding the number of hours residents performed their tasks. -There was no expectation for residents on the number of hours they performed their tasks. -She sometimes had to make Resident #6 stop her laundry tasks and told her she would have to limit her participation. -Regarding the laundry tasks, "that's a staff job, she's an assistant." -The program tasks was "how they [residents] get their money." -Staff had been told to "help with laundry." A third interview on 12/07/16 at 6:50AM with Resident #6 revealed: -She could open the door to the laundry room with the commercial washer and dryer to check for any dirty laundry from the night shift. -Residents were known to leave small piles of dirty clothing in front of the laundry room door. -She removed the clean clothes in the laundry basket the previous evening so she could do her own laundry. -There was otherwise no laundry in the room that required washing, drying or folding. Observation on 12/07/16 at 6:50AM of the laundry room with the commercial washer and dryer revealed: -A small pile of personal resident clothing on the floor in front of the locked door. -The washer and dryer were empty. -A basket of clean laundry was on the counter. Interview on 12/07/16 at 7:05AM with Staff A, PCA revealed: -She was familiar with the "Worker Bee" program.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 9 -She knew that Resident #6 did laundry. -Night shift staff, including herself, had done laundry. -A few months prior when "the water was messed up" night staff had to help get caught up with laundry that had piled up. -She was not aware of any complaints about laundry and there had been no reports of missing clothes. -No resident who had worked in the program had complained to her. -If Resident #6 was not able to do laundry, staff would have to take it over. -She could do a "couple of loads" when working night shift. -"It's hard enough with just me and [the medication aide] doing what we are doing." -During the time when staff had to assist with backed-up laundry, she washed and dried two loads of laundry but did not have time to fold it. Telephone interview on 12/07/16 at 4:40PM with the Family Nurse Practitioner revealed: -He was "indirectly aware" of the "Worker Bee" program. -If a resident participating in the program was complaining of back pain, he would give limitations to what the resident could do, and gave the example of Resident #6 folding towels. -He did not think he had done any "examination for fitness" of residents participating in the program. -He felt Resident #6 would perform the laundry task "even if there was no incentive." Telephone interview on 12/09/16 at 8:05AM with Staff B, Medication Aide (MA) revealed: -Resident #6 did laundry and "will keep doing it if you let her until 11:00PM at night." -Resident #6 needed encouragement to stop	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 10 doing laundry. -She would tell Resident #6 she would assist her in doing laundry but it was usually caught up by 11:00PM. -She had done laundry "quite often," doing it "a couple times a week." -She did not know if day shift staff did any laundry. -Laundry was a third shift responsibility for as long as she had worked at the facility (ten years), as staff did a lot on day shift. -The staff member who was scheduled to work from 1:00PM to 9:00PM was expected to "help more with it [laundry]." -Normal staffing on night shift was one MA and one PCA. -There were a couple of hours on night shift when there were no direct care tasks and non-direct care tasks like laundry and cleaning, could be done. -"[Resident #6] is basically doing it [the laundry]." -In the past (date could not be remembered) and for a few weeks, Resident #6 was in a cast in a wheelchair and could not get up to do laundry, and staff did laundry at that point. -"I've told [Resident #6] that she works harder than some staff." -She did not know anything regarding the amount of money residents were given for their completed tasks. Refer to review of the facility's admission contract. Refer to review of the facility's policy dated 01/28/14 and titled "Worker Bee- Resident Volunteer Program." Refer to review of the facility's "Worker Bee Volunteer Agreement and Waiver" form updated	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 11 on 01/28/14. Refer to review of the facility's "Worker Bee Volunteer- Position Description" form updated on 01/28/14. Refer to review of the facility's printed Volunteer Statement with the heading of "Work Type Activity Program." Refer to telephone interview on 12/06/16 at 4:35PM with the Owner. Refer to observation on 12/07/16 at 9:50AM. B. Review of Resident #7's current FL-2 dated 03/11/16 revealed: - Diagnoses included acute decompensated congestive heart failure, diabetes mellitus and end stage cardiomyopathy. -The resident as self-ambulatory with use of a wheelchair. -Continent of bowel and bladder. -An order to apply anti-thrombotic/compression stockings (TEDS or TED hose) to both legs every morning. Review of Resident #7's Resident Register revealed: -An admission date of 03/25/15. -The resident was his own responsible person. Review of a facility Job Classification description for Dietary Aide updated on 04/21/14 revealed the task "Make sure that all cooking materials and resident dinnerware is cleaned after each meal, and that the cleaning equipment is working properly." Review of Resident #7's Annual Activity Review	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 12 dated 08/08/16 revealed: - "Physical Restrictions" were documented as "unable to walk very far- [down arrow symbol for decreased] strength in upper and lower extremities." - "Work Type/Volunteer" was documented as "participates in 'worker bee' program." - "Comments" were documented as "does an excellent job in 'worker bee' program." Review of Resident #7's Licensed Health Support Professional's (LHPS) report dated 09/08/16 revealed: - The LHPS task of applying and removing TED hose to bilateral lower extremities. - The statement "limited mobility." - Staff were compliant with the orders and assistance with TED hose application. - The LHPS task of ambulation using assistive devices, with "wheelchair" noted as type of equipment. - "Staff assistance is required." - "Continue current plan of care" for TED hose and Ambulation with Assistive Devices. - No comments documented regarding volunteer work program. Review of a Plan of Service Summary for Resident #7 dated 11/09/16 revealed: - Limited assistance required in most activities of daily living. - Extensive assistance required in application of TEDS. Review of Resident #7's printed charting notes from the computerized record revealed: - An entry dated 10/20/16 documenting that measurements were provided to the contracted pharmacy/durable medical equipment provider for TEDS.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 13 -No entries during the review period of 07/03/16 through 12/04/16 concerning participation in the volunteer worker program. Review of Resident #7's Worker Bee Volunteer Agreement and Waiver dated 05/11/15 revealed: -The resident's signature and the signature of the Activity Coordinator. -Attached to the Agreement and Waiver was a Volunteer Statement with the resident's and Activity Coordinator's signatures, also dated 05/11/15. Review of Resident #7's "Worker Bee Volunteer-Position Description" revised on 01/28/14 revealed: - "Position Title" was documented as "Laundry & picking up cigarette butts." -An asterisk on a printed statement in the lower margin was hand written as "washes dishes only" with the initials of the Activity Coordinator. - "Supervisor" was documented as the Administrator and the Activity Coordinator. - "Benefits" was documented as "Encourage the use of their industrial skills and abilities in order to promote well-being and facilitate therapeutic use of mind & body." -No documented "Responsibilities," "Location or Department" or "Schedule" related to washing dishes but only for laundry and picking up cigarette butts. -The resident's and Activity Coordinator's signatures with the date of 05/11/15. Review of Resident #7's printed Volunteer Statement with the heading of "Work Type Activity Program" revealed the resident's signature, the signature of the Activity Coordinator and the date 05/11/15.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 14 Interview on 12/05/16 at 10:20AM with a resident revealed: -Resident #7 "helps in the kitchen." -The Cook was a facility employee and Personal Care Aides (PCAs) carried trays to residents and poured beverages, but Resident #7 did the dishwashing. Interview on 12/05/16 at 3:40PM with Resident #7 revealed: -The "Worker Bee" program was "great," as it provided "spending money." -He received \$50 a week "washing dishes." -It's [the worker program] therapy" and "I got something to do." -He has participated in the program for "about a year." -He washed "just dishes," which included trays, glasses, cups and silverware. -After trays were rinsed and put in racks, the racks were put in the dishwasher to "purify it [the trays]" with hot water. -The dishwasher had to reach a certain temperature to get the water hot. -"Someone" in the kitchen checked the temperature "once in a while," but he checked it every morning. -Washing the dishes was a "good job" and "I like it." -He washed dishes for all three meals each day, seven days a week. -Each meal required 1 to 1 ½ hours of dishwashing for approximately a total of 4 hours a day. -His participation in the program was all volunteer with no arm twisting and "I applied for it." -Another resident had previously washed dishes but when her arm "broke out" he was approached by the Cook when he worked the laundry. -When he worked the laundry, it required	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 15 washing, drying and delivering clothes, linens and towels, or "everything." - "Somebody" showed me how to use the dishwasher and to make sure the temperature gauge worked, but he could not remember who did this. - Since that initial training, there was no further training as he knew how to wash the dishes. - When he washed the dishes, he wore rubber gloves and did not touch any cleaning chemicals as they were dispensed into the dishwasher automatically. - If he were to be stopped being paid for the dishwashing, "I would not do it." - He thought the money he received was for "services rendered," "like a job." - He thought being paid \$50 a week was "about right" for working 3 to 4 hours a day, or approximately 22 to 23 hours a week. Observation on 12/06/16 at 8:45AM of the kitchen revealed: - The presence of the Cook and Resident #7, with no other employees or residents present. - Resident #7 standing at the sink and dishwasher. - Resident #7 was wearing a knit cap and had gloves on. - Resident #7 was placing plastic mugs in the sink full of soapy water, cleaning them with a scrub brush then placing them on a dishwasher rack. - Resident #7 placed the rack of mugs into the dishwasher, closed the door and the dishwasher remained in a wash cycle for approximately 3 minutes with the wash temperature reaching 150 degrees Fahrenheit (F) and the sanitizing rinse temperature reaching 178 degrees. A second interview on 12/06/16 at 8:45AM with Resident #7 revealed:	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 16 -He sanitized a wheeled cart used by the kitchen staff with a bleach and water solution. - "I don't know how hot it [the dishwasher] has to get" on temperature but "I put a sticker [a disposable heat sensitive monitoring strip] on the load with pitchers that tells me it's okay" and "the square [on the monitoring strip] turns black as temperature is reached" (the pitchers were in the first load run each day and the resident showed the heat sensitive monitoring strip, commonly used by kitchens to confirm the dishwasher reached temperature to ensure sanitizing). -He ran silverware through the dishwasher three times. -He emptied the food trap in the dishwasher every day after lunch. -That he was the only dishwasher the facility had. -That "a couple of weeks ago" he was unable to wash lunch dishes due to a medical appointment, but he paid another resident "\$3 to cover me." Interview on 12/06/16 at 8:45AM with the Cook revealed that Resident #7 was the only dishwasher the facility had. Observation on 12/06/16 at 9:10AM of Resident #7 revealed him located in the hallway outside the Activity Office, seated in a wheelchair and talking to the Activity Coordinator. Interview on 12/06/16 at 11:35AM with a resident revealed: -She used to wash dishes but a liquid dishwashing liquid gave her a rash and she had to stop. - "A couple of weeks ago" she did "cover" for Resident #7 when he was not available to wash dishes and he did give her \$3. -The Dietary Manager and the Cook knew that she had covered for Resident #7.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 17 -She was "okay to do it" and they changed the brand of dishwashing liquid so she did not have any rashes. -Resident #7 gave her the \$3 out of his money for washing dishes for just one meal, and "it was fair." -There were no other paid employees who worked in the kitchen other than the Dietary Manager and the Cook. -The Cook washed pots and pans. -Resident #7 washed plates, cups, silverware and "stuff like that." -PCAs did not wipe down chairs or clear tables, they had "occasionally" but it was "sparse." A second interview on 12/06/16 at 2:22PM with the Cook revealed: -She was employed to work in the kitchen. -PCAs had no kitchen responsibilities. -Working in the kitchen was "overwhelming sometimes." -When she worked, she supervised Resident #7. -She did not know if Resident #7 received training. -She knew these residents were paid a "little extra money" but she was not aware of the amount as that was "confidential." -Sometimes when Resident #7 rushed he would put too many items too close together in the dishwasher racks resulting in the dishes not getting clean, and she would tell him in a "nice way" but Resident #7 would reply that he knew what he was doing. -She washed the can opener and other items she knew she would need for food preparation. -If Resident #7 did not perform his kitchen/dining room tasks, she was not sure who would perform them. Interview on 12/06/16 at 3:10PM with the Activity	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 18 Coordinator revealed: -She had been the Activity Coordinator since 2013, when the current Owner assumed management responsibilities. -The Owner brought to the facility the "Worker Bee" program from another facility with a list of positions that residents could work. -Both she and the Administrator managed the program, including making job changes. -If residents in the program work the program, they were paid every Wednesday in cash, with the amount prorated for days missed. -The Administrator wrote a check from an account for this purpose, cashed it and the money was disbursed. -Previously the residents were paid a "little more," "a fair amount," but she and the Administrator were told to "cut back" by the Owner. -A lot of employed staff "come and go." -Any resident assessments done for the program were not put into writing, but she and the Administrator had talked about the residents' abilities to do the tasks. -Training in kitchen was provided for the cooks but otherwise the residents working there did not receive any formal training. -There were no records kept of how many hours of work each resident in the program completed for their tasks. -She thought Resident #7 was "replacing an employee." -Residents have asked her to find them something to do to "make some money." -No employees were let go for these tasks to have them replaced with and be done by residents. Interview on 12/06/16 at 3:45PM with the Administrator revealed: -The Owner had a problem at another facility with	D 320			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 19 a volunteer program and the Agreement was created, with review "at the State level." -The resident or Guardian was required to sign the Agreement. -She, the Activity Coordinator and the Department Heads provided oversight for the program. -There was no documentation available regarding resident performance at assigned tasks. -There was no documentation available regarding the number of hours residents performed their tasks. -There was no expectation for residents on the number of hours they performed their tasks. -The program tasks was "how they [residents] get their money." -As the Owner made the Cook and Dietary Manager take a two hour break, she did not see how they could wash dishes. Interview on 12/07/16 at 7:05AM with Staff A, PCA revealed: -She was familiar with the "Worker Bee" program. -She had seen the Dietary Manager and the Cook wash dishes and knew that Resident #7 washed dishes but had never directly seen him do the task. -No resident who had worked in the program had complained to her. Telephone interview on 12/07/16 at 4:40PM with the Family Nurse Practitioner revealed: -He was "indirectly aware" of the "Worker Bee" program. -If a resident participating in the program was complaining of back pain, he would give limitations to what the resident could do. -He did not think he had done any "examination for fitness" of residents participating in the program. -The order for TED hose for Resident #7 was for	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 20 "when he was not in as great shape as he is now." Refer to review of the facility's admission contract. Refer to review of the facility's policy dated 01/28/14 and titled "Worker Bee- Resident Volunteer Program." Refer to review of the facility's "Worker Bee Volunteer Agreement and Waiver" form updated on 01/28/14. Refer to review of the facility's "Worker Bee Volunteer- Position Description" form updated on 01/28/14. Refer to review of the facility's printed Volunteer Statement with the heading of "Work Type Activity Program." Refer to telephone interview on 12/06/16 at 4:35PM with the Owner. Refer to observation on 12/07/16 at 9:50AM. C. Review of Resident #10's current FL-2 dated 04/29/16 revealed: -Diagnoses included a history of coronary artery disease, atrial flutter, traumatic brain injury and history of degenerative disc disease. -An order for Butrans transdermal patch, 10 mcg/hr, change the patch every 7 days (this is a narcotic pain medication for chronic pain not relieved by other medication). Review of Resident #10's Resident Register revealed: -An admission date of 04/01/13.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 21 -The resident was his own responsible person. Review of a facility Job Classification description for Housekeeping updated on 01/15/13 revealed the task "Empty and clean all trash cans located throughout the facility." Review of a facility Job Classification description for Dietary Aide updated on 04/21/14 revealed the task "Assist in cleaning floors in kitchen and dining room area." Review of Resident #10's Annual Activity Review dated 08/08/16 revealed: - "Outdoor Activities" were documented as "rakes leaves, pick up trash outside, etc." - "Work Type/Volunteer" was documented as "participates in 'worker bee' program." Review of a Plan of Service Summary for Resident #10 dated 02/26/16 revealed: - Limited assistance required on most activities of daily living. - Independent in transfers and ambulation. Review of Resident #10's printed charting notes from the computerized record revealed: - Documentation dated 08/29/15 of "Resident has refused to take trash off today using various excuses as to why he cannot take trash out. Resident was reminded by staff that he wasn't going to do the job, then he wouldn't be paid for it and that he needed to let someone else do the job." - Documentation dated 09/22/16 of "Admin[istrator] spoke with resident today regarding his job of taking out the trash. Admin. Stated that multiple people had made complaints of trash over-flowing, not taken out, and of [Resident #10] being rude to residents when	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 22 residents ask him to get trash. Admin. asked if resident still wanted job to which resident responded yes. Admin. stated do your job, and do it consistently." -Documentation dated 11/04/16 to increase the dose of the Butrans transdermal patch to 15 mcg/hr, one topical patch per week. Review of Resident #10's Worker Bee Volunteer Agreement and Waiver dated 03/06/14 revealed: -The resident's signature and the signature of the Activity Coordinator. -Attached to the Agreement and Waiver was a Volunteer Statement with the resident's and Activity Coordinator's signatures, also dated 03/06/14. Review of Resident #10's "Worker Bee Volunteer-Position Description" revised on 01/28/14 revealed: - "Position Title" was documented as "mop dining room, take up trash over building." - "Responsibilities" were documented as "mop dining room" and "take up trash all over building, place in dumpster." - "Supervisor" was documented as the Administrator and name of an unknown staff member. - "Schedule" was documented as "mop three times daily, remove trash as needed, at least daily." - "Benefits" were documented as "Encourage use of their industrial skills and abilities in order to promote well-being and facilitate therapeutic use of mind & body." - No documentation in block for "Support Provided." - The signatures of the resident, the Activity Coordinator, and the date of 03/06/14.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 23 Review of Resident #10's printed Volunteer Statement with the heading of "Work Type Activity Program" revealed the Resident #10's signature, the signature of the Activity Coordinator and the date 03/06/14. Interview on 12/06/16 at 3:10PM with the Activity Coordinator revealed: -She had been the Activity Coordinator since 2013, when the current Owner assumed management responsibilities. -The Owner brought to the facility the "Worker Bee" program from another facility with a list of positions that residents could work. -Both she and the Administrator managed the program, including making job changes. -If residents in the program work the program, they were paid every Wednesday in cash, with the amount prorated for days missed. -The Administrator wrote a check from an account for this purpose, cashed it and the money was disbursed. -Previously the residents were paid a "little more," "a fair amount," but she and the Administrator were told to "cut back" by the Owner. -Resident #10 collected trash "rain or shine" and took it to the dumpster. -Resident #10 was not getting paid enough and worked "like an employee." -A lot of employed staff "come and go." -Any resident assessments done for the program were not put into writing, but she and the Administrator had talked about the residents' abilities to do the tasks. -There were no records kept of how many hours of work each resident in the program completed for their tasks. -She thought Resident #10 was "replacing an employee." -Residents have asked her to find them	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 24 something to do to "make some money." -No employees were let go for these tasks to have them replaced with and be done by residents. Interview on 12/07/16 at 11:10AM with Resident #10 revealed: -He had been part of the "Worker Bee" program for "close to 4 years." -His tasks included going through the building to get all the trash out of the bathrooms and individual resident rooms and mopping the Dining Room floor after each meal three times a day. -He took the trash to the dumpster in "all kinds of weather, rain, snow." -It was not an "extreme job. " -"I love doing it, gives me some extra pay, keeps me from getting bored." -He also collected trash from the kitchen. -He wore gloves when collecting trash and used a wheelbarrow with "nothing to it." -He would ask the Housekeeper for assistance with heavier trash bags. -"I've got a scarred heart" but it did not affect him. -Other medical history included "two crushed vertebrae" in his neck, a broken shoulder and "two vertebrae in my lower back." -He used a low dose morphine patch for a pain level that "stayed the same" and covered him on an average day. -If dosing for an oral pain medication which he took four times a day was changed back to its original dosing, he would be "much better off" for his "job performance." -Gathering trash "helps me physically" as having a "job" helped him "move around." -His attending provider was aware of his job and his pain as he was the one who prescribed him the patch. -There was no coercion regarding his	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 25 participation in the program, he volunteered and "I'm grateful to do it." -He performed his tasks, "maybe 4 hours," 4 ½ hours a day," "3 to 4 hours." -He was paid \$50 each week, on Wednesdays, and the Activity Coordinator assisted him in getting a little more money. -"[Vice President of corporation owning facility] acted like they wanted to cut everyone's pay." -If he could not do the task, the facility could probably find someone to do it. -The money he received for doing the task really helped. -If for some reason the money received was to be stopped, he did not know if he would continue doing the task. -It wouldn't hurt [VP of corporation] and [President of corporation] to give us [participant's in program] a raise." Interview on 12/07/16 at 7:05AM with Staff A, PCA revealed: -She was familiar with the "Worker Bee" program. -Resident #10 gathered trash from all over the facility. -No resident who had worked in the program had complained to her. -"It's hard enough with just me and [the medication aide] doing what we are doing." Refer to review of the facility's admission contract. Refer to review of the facility's policy dated 01/28/14 and titled "Worker Bee- Resident Volunteer Program." Refer to review of the facility's "Worker Bee Volunteer Agreement and Waiver" form updated on 01/28/14.	D 320			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 26 Refer to review of the facility's "Worker Bee Volunteer- Position Description" form updated on 01/28/14. Refer to review of the facility's printed Volunteer Statement with the heading of "Work Type Activity Program." Refer to interview on 12/06/16 at 3:45PM with the Administrator. Refer to telephone interview on 12/06/16 at 4:35PM with the Owner. Refer to observation on 12/07/16 at 9:50AM. D. Review of Resident #4's current FL-2 dated 03/06/16 revealed: -Diagnosis of bipolar disorder mixed with delusions. -The resident was ambulatory and continent of bowel and bladder. Review of Resident #4's Resident Register revealed: -An admission date of 08/07/06. -The name of a Guardian. Review of a facility Job Classification description for Dietary Aide updated on 04/21/14 revealed: -The task "To assist with cleaning all kitchen and dining room areas, and special assigned cleaning tasks as instructed by the dietary technician." -The task "Assist in cleaning floors in kitchen and dining room area." Review of Resident #4's Annual Activity Review dated 08/03/16 revealed: -"Physical Restrictions" were documented as	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 27 "none known." -"Work Type/Volunteer" was documented as "Participates in 'worker bee' program." Review of a Plan of Service Summary for Resident #4 dated 03/16/16 revealed: -Limited assistance required for most activities of daily living. -Limited assistance required for category of "clean utensils/dishes, empty trash" and "clean meal service area." -The resident's signed name and date of 03/16/16 and the printed name of the Owner. Review of Resident #4's printed charting notes from the computerized record revealed an entry dated 07/03/16 of "Resident has also been staying in the kitchen after her work is completed. Kitchen staff feels that resident needs to leave with other kitchen help, and go to her room in between meals instead of hanging out in the kitchen. Resident is also telling other residents what condiments they can have a[t] meal times. Will report to Admin[istrator] and follow up accordingly." Review of Resident #4's Worker Bee Volunteer Agreement and Waiver dated 03/06/14 revealed: -The resident's signature and the signature of the Activity Coordinator. -Attached to the Agreement and Waiver was a Volunteer Statement with the resident's and Activity Coordinator's signatures, also dated 03/06/14. Review of Resident #4's "Worker Bee Volunteer- Position Description" revised on 01/28/14 revealed: -"Position Title" was documented as "pour beverages, put silverware, napkins, water on	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 28 tables- sweep." - "Responsibilities" were documented as "pour milk, tea, juice, fill water pitchers," "place napkins & silverware on tables" and "sweep." - "Supervisor" was documented as the name of an unknown staff member. - "Schedule" was documented as three times a day. - "Benefits" were documented as "Encourage use of their industrial skills and abilities in order to promote well-being and facilitate therapeutic use of mind & body." - No documentation in block for "Support Provided." - The signatures of the resident, the Activity Coordinator, and the date of 03/06/14. Observation on 12/05/16 at 10:20AM of Resident #4 in her room revealed: - She was wearing a bandana tied around her head. - She was wearing a full-length cloth apron. Interview on 12/05/16 at 10:20AM of Resident #4 revealed: - "I work in the dining room" and in the kitchen, wiping down chairs and "do trays" after each meal. - She had done this work for "maybe five years." - "We [she and her roommate] like the extra money" and the work "gives a feeling of purpose." - The work was "all volunteer." - She "makes \$15 a week." - She worked before and after each meal for approximately 7 hours a day or 49 hours a week. - "I would like a little more" money, "like \$25 to \$30 a week." - She had signed an agreement regarding the work but the amount of money given was verbalized.	D 320			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 29 -In the kitchen, she filled pitchers with ice and water and swept the floor after each meal. -In the dining room, she set the tables with silverware. -If she needed assistance for her tasks, she would ask another resident. -She could not remember if she ever received formal training for her tasks. Observation on 12/05/16 at 11:30AM of the kitchen revealed: -The presence of the Dietary Manager, who was working as the Cook. -The presence of Resident #4, who was wearing a bandana on her head, an apron and disposable gloves while scooping ice in clean pitchers. Telephone interview on 12/06/16 at 7:59AM with Resident #4's Guardian revealed: -She was aware that the resident worked in the kitchen and had seen her in the past performing her tasks. -She felt the resident enjoyed the work and that it gave her purpose. -She did not know how many hours a week the resident performed her kitchen tasks. -She was not aware that the resident had signed an agreement regarding this work. -She did not know how much money the resident was receiving for performing this work. -She did not think the resident was being exploited in performing the tasks as she did so willingly. -She did not know if the resident would continue the kitchen tasks if she was not longer paid. Interview on 12/06/16 at 2:22PM with the Cook revealed: -She was employed to work in the kitchen. -PCAs had no kitchen responsibilities.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 30 -Working in the kitchen was "overwhelming sometimes." -Resident #4 set up tables and placed utensils. -Resident #4 in the past had poured beverages but was told not to do that anymore, "the State said this, I think." -Before she left employment at the facility in May, 2016 Resident #4 was pouring beverages and making tea and coffee, but when she returned in October, 2016 that "all changed" and she did not know the reason for the change. -When she worked, she supervised Resident #4. -She did not know if Resident #4 received training. -She knew these residents were paid a "little extra money" but she was not aware of the amount as that was "confidential." -Resident #4 had done her kitchen/dining room tasks for 5 to 6 years, she knew all the residents who were diabetic and who received supplemental nutritional shakes, but the Cook gave them to the residents. -Resident #4 or a PCA would help pass meal trays to residents as they were plated by the Cook. -If Resident #4 did not perform her kitchen/dining room tasks, she was not sure who would perform them. Interview on 12/06/16 at 3:10PM with the Activity Coordinator revealed: -She had been the Activity Coordinator since 2013, when the current Owner assumed management responsibilities. -The Owner brought to the facility the "Worker Bee" program from another facility with a list of positions that residents could work. -Both she and the Administrator managed the program, including making job changes. -If residents in the program work the program,	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 31 they were paid every Wednesday in cash, with the amount prorated for days missed. -The Administrator wrote a check from an account for this purpose, cashed it and the money was disbursed. -Previously the residents were paid a "little more," "a fair amount," but she and the Administrator were told to "cut back" by the Owner. -A lot of employed staff "come and go." -Any resident assessments done for the program were not put into writing, but she and the Administrator had talked about the residents' abilities to do the tasks. -Resident #4 was doing more with her kitchen/dining tasks previously but is doing much less now and was no longer pouring beverages. -Resident #4 should not have been in the kitchen for more than 1 to 1 ½ hours per meal. -Training in kitchen was provided for the cooks but otherwise the residents working there did not receive any formal training. -There were no records kept of how many hours of work each resident in the program completed for their tasks. -Residents have asked her to find them something to do to "make some money." -No employees were let go for these tasks to have them replaced with and be done by residents. Refer to review of the facility's admission contract. Refer to review of the facility's policy dated 01/28/14 and titled "Worker Bee- Resident Volunteer Program." Refer to review of the facility's "Worker Bee Volunteer Agreement and Waiver" form updated on 01/28/14.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 32 Refer to review of the facility's "Worker Bee Volunteer- Position Description" form updated on 01/28/14. Refer to review of the facility's printed Volunteer Statement with the heading of "Work Type Activity Program." Refer to interview on 12/06/16 at 3:45PM with the Administrator. Refer to telephone interview on 12/06/16 at 4:35PM with the Owner. Refer to interview on 12/07/16 at 7:05AM with Staff A, PCA. Refer to observation on 12/07/16 at 9:50AM. Refer to telephone interview on 12/07/16 at 4:40PM with the Family Nurse Practitioner. E. Review of Resident #3's current FL-2 dated 04/29/16 revealed: -Diagnoses included schizophrenia and reactive airway disease. -The resident was ambulatory and continent. Review of Resident #3's Resident Register revealed an admission date of 04/05/81. Review of a facility Job Classification description for Dietary Aide updated on 04/21/14 revealed: -The task "To assist with cleaning all kitchen and dining room areas, and special assigned cleaning tasks as instructed by the dietary technician." -The task "Assist in cleaning floors in kitchen and dining room area."	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 33 Review of Resident #3's Annual Activity Review dated 08/3/16 revealed she participated in the "Worker Bee" program daily. Review of a Plan of Service Summary for Resident #3 dated 08/05/16 revealed her need of limited supervision for mobility Review of Resident #3's printed charting notes from the computerized record revealed no documentation regarding her participation in the "Worker Bee" program from 07/08/16 through 12/03/16. Review of Resident #3's Worker Bee Volunteer Agreement and Waiver dated 03/06/14 revealed: -The resident's signature and the signature of the Activity Coordinator. -Attached to the Agreement and Waiver was a Volunteer Statement with the resident's and Activity Coordinator's signatures, also dated 03/06/14. Review of Resident #3's "Worker Bee Volunteer-Position Description" revealed: -"Position Title" was documented as "wash dishes, clean tables (scrap[e] plates, pick up [illegible word])." -"Responsibilities" were documented as "scrap[e] plates/[illegible word], "pick up silverware," "wipe tables and sanitize," and "wash dishes." -"Location or Department" was documented as "dining room & kitchen." -"Supervisor" was documented as "[proper name of employee no longer at the facility]." -"Schedule" was documented as "three meals a day." -"Benefits" were documented as "Encourage use of their industrial skills and abilities in order to promote well-being and facilitate therapeutic use	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 34 of mind & body." -"Support Provided" was blank. -Signatures for the resident and the Activities Coordinator with the date of 03/06/14. Review of a second "Worker Bee Volunteer- Position Description" for Resident #3 revealed -The handwritten statement in the lower margin of "amended on 12-12-16- Resident does not do dish washing any longer- only assists in dining room." -"Position Title" was documented as "assists in cleaning of tables, plates, cups, utensils." -"Responsibilities" were documented as "scrap[e] plates," "pick up silverware," and "wipe tables/sanitize." -"Location or Department" was documented as "dining room." -"Supervisor" was documented as "Cook, [Administrator], [Activities Coordinator]." -"Schedule" was documented as "3x's daily." -"Benefits" were documented as "Encourage use of their industrial skills and abilities in order to promote well-being and facilitate therapeutic use of mind & body." -"Support Provided" was blank. -Signatures for the resident and the Activities Coordinator with the date of 12/12/16. Interview on 12/05/16 at 10:20AM of Resident #3 revealed: -Another resident mopped the floor in the dining room. -The work was "all volunteer." -She worked after each meal for a total of approximately 21 hours a week. -She made \$10 a week. -She did not think she was paid enough and thought she should make \$20 a week. -The amount she was paid was cut down "far	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 35 back." -She had worked for "35 years." -She had signed an agreement regarding the work. Interview on 12/06/16 at 3:10PM with the Activity Coordinator revealed: -She had been the Activity Coordinator since 2013, when the current Owner assumed management responsibilities. -The Owner brought to the facility the "Worker Bee" program from another facility with a list of positions that residents could work. -Both she and the Administrator managed the program, including making job changes. -If residents in the program work the program, they were paid every Wednesday in cash, with the amount prorated for days missed. -The Administrator wrote a check from an account for this purpose, cashed it and the money was disbursed. -Previously the residents were paid a "little more," "a fair amount," but she and the Administrator were told to "cut back" by the Owner. -A lot of employed staff "come and go." -Any resident assessments done for the program were not put into writing, but she and the Administrator had talked about the residents' abilities to do the tasks. -There were no records kept of how many hours of work each resident in the program completed for their tasks. -Residents have asked her to find them something to do to "make some money." -No employees were let go for these tasks to have them replaced with and be done by residents. Refer to review of the facility's admission contract.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 36 Refer to review of the facility's policy dated 01/28/14 and titled "Worker Bee- Resident Volunteer Program." Refer to review of the facility's "Worker Bee Volunteer Agreement and Waiver" form updated on 01/28/14. Refer to review of the facility's "Worker Bee Volunteer- Position Description" form updated on 01/28/14. Refer to review of the facility's printed Volunteer Statement with the heading of "Work Type Activity Program." Refer to interview on 12/06/16 at 3:45PM with the Administrator. Refer to telephone interview on 12/06/16 at 4:35PM with the Owner. Refer to interview on 12/07/16 at 7:05AM with Staff A, PCA. Refer to observation on 12/07/16 at 9:50AM. Refer to telephone interview on 12/07/16 at 4:40PM with the Family Nurse Practitioner. <u>Review of the facility's admission contract revealed, under the heading of General Policies, the clause "No resident is required to perform any work-related assignments by oral or written agreement while residing at [facility's name]. Any work-related task will be done on a volunteer basis as requested by attending physician for work-related therapy or as a diversional act."</u>	D 320			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 37 Review of the facility's policy dated 01/28/14 titled "Worker Bee- Resident Volunteer Program" revealed: -Under the heading of "Policy," the statement "To provide a work-type activity program for residents. To encourage industrious use of their skills and abilities in order to encourage and promote their well-being, and to help facilitate therapeutic use of mind and body." -"Residents should only perform volunteer duties for which they have been adequately trained, and should not routinely perform duties without supervision by staff." -"Residents should not be left in restricted areas without direct supervision of staff, unless otherwise authorized by the Administrator (i.e. areas that are typically locked from resident access)." -"Residents must sign a Volunteer Agreement and Waiver prior to participating in the program." -"All Worker Bee participants should have a Worker Bee Position Description, which clearly outlines the resident's volunteer responsibilities." -"All Worker Bee participants will have their volunteer activities recorded throughout the week by their designated supervisor." -"Activities personnel will collect and compile this information each week and calculate any gratuities due." -"Residents participating in the Worker Bee program may be given financial gratuities for completion of their volunteer duties." -"Tasks that are typically completed by a Worker Bee, must be completed by the responsible staff member if not completed by a Worker Bee." -"This program is not to be construed as an employee/employer relationship, all residents who participate do so as volunteers and any financial considerations given by [corporate owner of facility] or its affiliated communities is done so as	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 38 a token of appreciation for their efforts." Review of the "Worker Bee Volunteer Agreement and Waiver" updated on 01/28/14 revealed: -"The resident understands that any gratuities earned are given to them as a token of appreciation for their efforts." -"The Worker Bee program is not intended to be, nor will it be treated as an employee/employer relationship." -"Resident volunteers should be adequately trained prior to performing a volunteer duty, it is the resident's responsibility to notify staff if they do not understand how to complete the assigned duties." -"All duties are to be completed during the assigned times, and under staff supervision." -"The resident understands that they are not to perform any task(s) that they feel is too physically demanding, or that they do not feel safe performing." -"The resident or their responsible party agrees to indemnify and hold harmless, [corporate owner of facility], its officers, agents, residents, and visitors from and against any liability whatsoever arising out of or related to my duties under this agreement." -"The resident (or their responsible party) understands there may be risks associated with the services the resident is volunteering to perform, and on behalf of the resident, their heirs, assignees, guardians, personal, and legal representatives and executors, I hereby release, discharge, indemnify, and hold harmless [corporate owner of facility], its officers, agents, and volunteers from any claims, demands, losses, costs, liabilities, damages and expenses connected with my services to or for [corporate owner of facility]." -"I fully understand that [corporate owner of	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 39 facility] does not provide resident volunteers with medical insurance, workman's compensation, or automobile liability coverage." -Printed lines for a resident signature, responsible party signature (if applicable), corporate representative signature and dates. Review of the "Worker Bee Volunteer- Position Description" revised 01/28/14 revealed: -Printed lines for the resident's name, their signature, the corporate representative's signature, and date. -Blocks for documentation of Position Title, Purpose, Responsibilities, Location or Department, Supervisor, Schedule, Benefits and Support Provided. Review of a printed Volunteer Statement with the heading of "Work Type Activity Program" revealed: -Statements of responsibility for the resident for personal hygiene and their living area. -The statement "I understand that this is done on a voluntary basis and that I am in no way being forced to perform any work task within or outside of the facility by the administration." -The statement "Any compensation is an appreciation of effort from the facility and not intended to be considered a wage comparison for work performed." -Printed lines for a "Volunteer signature," a facility staff representative signature, signature dates and work type activity. Interview on 12/06/16 at 3:45PM with the Administrator revealed: -The Owner had a problem at another facility with a volunteer program and the Agreement was created, with review "at the State level." -The resident or Guardian was required to sign	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 40 the Agreement. -She, the Activity Coordinator and the Department Heads provided oversight for the program. -There was no documentation available regarding resident performance at assigned tasks. -There was no documentation available regarding the number of hours residents performed their tasks. -There was no expectation for residents on the number of hours they performed their tasks. -The program tasks was "how they [residents] get their money." Telephone interview on 12/06/16 at 4:35PM with the Owner revealed: -The "Worker Bee" program was a volunteer program that permitted able and willing residents to engage in "chores." -The program permitted residents to volunteer for jobs that "helps with staff already there [in the facility]." -Examples of jobs included doing laundry and gathering trash. -"Payment for services" for the jobs was "not implied." -Money given to residents for the jobs was "more like a token of our appreciation for their help" as they "help the staff." -For some residents in the program, it was "not a money thing" and perhaps they were given "cable in their rooms." -It was "helpful" and "therapeutic" for residents to be engaged in the program. -The residents in the program were "there to assist the staff, not replace staff." -Staff had job descriptions which documented their responsibility to complete the tasks done by the residents in the program. -In the absence of the residents in the program, staff were expected to do the work.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 41 -She would "absolutely" hire staff to complete the tasks, if necessary. -There were records of days residents completed tasks, but not the number of hours logged "per se." -She relied on the Administrator and Activity Coordinator to determine if residents were capable of performing certain tasks and "obviously" a person in a wheelchair might be limited. -The facility had a housekeeper, maintenance staff and two staff members in the kitchen on one day of the week. -If residents could not perform the tasks in the program "we would do with what we got [current staffing]." Interview on 12/07/16 at 7:05AM with Staff A, PCA revealed: -She was familiar with the "Worker Bee" program. -No resident who had worked in the program had complained to her. -If Resident #6 was not able to do laundry, staff would have to take it over. -"It's hard enough with just me and [the medication aide] doing what we are doing." Observation on 12/07/16 at 9:50AM revealed an overhead announcement requesting residents in the "Worker Bee" program to report to the Administrator's office to "get paid." Telephone interview on 12/07/16 at 4:40PM with the Family Nurse Practitioner revealed: -He was "indirectly aware" of the "Worker Bee" program. -If a resident participating in the program was complaining of back pain, he would give limitations to what the resident could do. -He did not think he had done any "examination	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 42 for fitness" of residents participating in the program. The facility failed to prevent 5 of 10 residents (Residents #3, #4, #6, #7 and #10) from predominantly performing tasks which would have otherwise been performed by paid employees. The residents were participants in a volunteer work program whose hours were not monitored and whose pre-existing health conditions were not assessed to determine their participation; in particular, Residents #6, #7 and #10 worked tasks excessive in hours for a volunteer program and had significant health conditions that required participation consideration. The failure of the facility in permitting residents to volunteer for tasks in place of staff was detrimental to the welfare of the residents and constitutes a Type B violation. A Plan of Protection was obtained from the facility dated 12/06/16 and included: -The Facility would review the volunteer program to ensure the needs and rights of all volunteer residents were addressed. -The Facility would make sure with current participants that they understood and felt that the program was strictly voluntary. -The Facility would have staff in place to complete any tasks that volunteers were unable or unwilling to complete. -The Facility would make sure all staff were aware that tasks were the primary responsibility of the paid staff and the volunteer residents were to assist with those tasks and were never intended to replace staff. -The Facility would review on a monthly basis with all participants that the program was voluntary and staff were available to assist with any or all volunteer tasks.	D 320		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL012040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/12/2016
NAME OF PROVIDER OR SUPPLIER JONAS RIDGE ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 9051 HWY 181 JONAS RIDGE, NC 28641		
(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 320	Continued From page 43 -The Facility would re-educate staff so that if they became aware that a resident volunteer was unable to complete a task, staff would make sure that the task was completed. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 26, 2017.	D 320		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure residents were free from exploitation related to their participation in a volunteer work program. Based on observations, record reviews and interviews, the facility failed to prevent 5 of 10 residents (Residents #3, #4, #6, #7 and #10) from working an excessive number of hours and to properly assess impact on on pre-existing health conditions as participants of a volunteer work program, predominantly performing tasks which would have otherwise been performed by paid employees [Refer to Tag 320, 10A NCAC 13F .0905(g), Activities Program (Type B Violation)].	D914		