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	FCL001140	A. BUILDING: _____ B. WING _____	R 07/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	3524 DICKEY MILL ROAD MEBANE, NC 27302

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 7/07/17.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure walls and ceilings, in residents' bathrooms, hallway and floor coverings in the living room were kept clean and in good repair. The findings are: Observation on 7/07/17 at 9:30 a.m. of the living room, hallway at the dining room revealed: - The carpet in the living room had a brown stain in front of the couch where residents sat. - The corner where the dining room wall and the hallway met was cracked and missing paint all the way up approximately 5 feet from the floor. - The wood baseboard in the hallway from the dining room to the kitchen was broken, cracked and had missing paint. - The door frame molding of a door in the hall was broken with sharp edges. Interview on 7/07/17 at 2:30 p.m. with the Supervisor-In-Charge (SIC) revealed: - The cracked wall and base board in the hall way	C 074		

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C 074	Continued From page 1	C 074		

and the living room rug had been in this condition since she started work in the summer of last year.
- The Administrator knew about the condition of the wall and baseboards in the bathrooms and the hallway.
-She had put moth balls down in the hole in the wall in resident bathroom #3 to prevent vermin from entering.
- She thought the handyman had been told about the repair needs.
- The Administrator was not available at this time for interview as she was out of town.

- There was a golf ball size hole in the wall behind the toilet to the left in bathroom #1.
- There was a golf ball size hole in the wall behind the door handle in bathroom #1.
- There was a brown rim around the base of the toilet on the floor in bathroom #1.
- There was an area about the size of a football in the ceiling where paint was peeling containing a quarter sized hole in bathroom #2.
- There is a golf ball size hole beside the pipe exending from the floor to the left of the toilet in bathroom #3.

Interview on 7/07/17 at 11:31 a.m. with the SIC revealed:
-\The SIC cleaned the bathrooms daily and there was not a deep cleaning schedule.
-The sink in bathroom #2 often clogged up and the residents would attempt to fix it themselves.
- The SIC reported that in order to have items repaired in the home, she had to call the Nurse Manager and then she called the Administrator.
- The Administrator would then call the handyman and give authorization for him to make the necessary repairs.
- The repairs were an ongoing problem with the

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C 074	Continued From page 2 resident population in the home. - The Administrator was aware of the needed repairs and they were to be fixed soon. Interview on 7/07/17 at 6:30 p.m. with the Nurse Manager revealed: -She and the Administrator were aware of the concerns with the walls and repairs and the holes and cleaning needs. -The handyman repairs the sinks and toilets frequently and the bathrooms and resident rooms should be cleaned on a daily basis. -He paints areas frequently that have been broken. -The holes where vermin can get in would be looked at again immediately. -The Administrator was not available for interview. Observation on 7/07/17 at 9:45 a.m. of the resident bathroom #1 revealed: - The paint on the wall behind the toilet on the baseboard had paint scraped off and had chips of paint missing.	C 074		
C 153	10A NCAC 13G .0501 (a) Personal Care Training And Competency 10A NCAC 13G .0501 Personal Care Training And Competency (a) The facility shall assure that personal care staff and those who directly supervise them in facilities without heavy care residents successfully complete a 25-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section. For the purposes of this Subchapter, heavy care residents are those for whom the facility is providing personal care tasks	C 153		

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C 153	Continued From page 3 listed in Paragraph (i) of this Rule. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure 1 of 2 sampled staff (A) in the facility had completed the 25 hours of personal care training within six months of hire. The findings are: Review of the personnel record for Staff A revealed: -There was a hire date of 8/11/16. -Staff A was hired as a Medication Aide/Supervisor in Charge (SIC). -There was no documentation of the personal care training in the personnel record. Interview with Staff A on 7/7/17 at p.m. revealed she had taken the course and had a copy of her certificate at home. Observation during the survey on 7/07/17 from 9:15 a.m. - 6:45 p.m. revealed she had cleaned, cooked meals, administered medications and assisted residents as needed. Interview on 7/07/17 at 11:15 a.m. with Staff A revealed she assisted at least one resident with bathing since the resident was limited with his ability to be independent with some activities of daily living. Interview on 7/07/17 at 5:45 p.m. with Staff A revealed: -She did not have information related to having	C 153		

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C 153	Continued From page 4 completed 25 hours of personal care training. -A nurse was going to provide personal care training next week at the facility. -The Administrator told Staff A she had a year to complete the personal care training and that time would be up next week. Interview with the Nurse Manager on 7/7/17 at 6:45 PM revealed: -Staff A had taken the personal care training and there was a copy of the certificate in the personnel record at the remote office. -She would provide the documentation when she could get back into the office. No information regarding Staff A's personal care training was provided by the end of the survey	C 153		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision of 1 of 1 residents (#1) sampled resulting in the resident placing himself and others in danger by smoking outside of the facility while using oxygen. The findings are: Review of resident #1's current FL-2 dated	C 243		

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C 243	Continued From page 5 6/29/17 revealed: -Diagnoses include Acute Respiratory Failure with Hypoxia & Hypercapnia, Anxiety, Depression, Obstructive Sleep Apnea-Bipap, Chronic Obstructive Pulmonary Disease, and Tobacco Abuse. -Resident #1 was oriented, semi-ambulatory, and could be verbally abusive. Review of Resident #1's Assessment and Care Plan dated 2/24/17 revealed: -Resident #1 had limited ambulation ability due to paralysis of the left arm due to a car accident and used a walker. -Resident #1 wore a nasal cannula for continuous oxygen at five liters. -Resident #1 required supervision with ambulation and supervision while transferring. -There was no information related to the need of supervision with smoking and oxygen use on the assessment and care plan. Review of Resident #1's Resident Register dated 1/20/17 revealed Resident #1 smoked two to three packs of cigarettes daily. Observation on 7/07/17 at 9:15 a.m. revealed: -Three residents were on the front porch smoking. -Resident #1 was seated and was smoking with his medium sized portable oxygen tank with nasal cannula and tubing against the wall about two feet from his seat. -No staff were observed to be supervising the resident while smoking with the oxygen on the front porch. Interview with Resident #1 on 7/07/17 at 10:00 a.m. revealed: -Resident #1 had been living there for about six	C 243		

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C 243	Continued From page 6	C 243		

months.
-He wore oxygen all the time and had a concentrator for his room.
-He also had portable tanks to use when he went out of the house.
-He used a nebulizer and had a Bipap machine.

Observation of Resident #1 on 7/07/17 at 11:45 a.m. revealed:
-No staff was supervising the resident while on the porch smoking with the oxygen tank next to him.
-Resident #1 returned from smoking outside on the porch with his oxygen in hand.
-He put on the nasal cannula tubing to the concentrator used when in his bedroom.

Review of Resident #1's Report of Health Services to Residents revealed:
-The SIC had documented discussions with the resident about not smoking while using the oxygen on 2/15/17, 2/20/17, 3/15/17, and 4/10/17. The SIC documented the resident refused to listen, continued to smoke, and responded by cursing at staff.

Review of Resident #1's Licensed Health Professional Support Review (LHPS) revealed:
-The LHPS Review dated 4/20/17 indicated Resident #1 had been counseled regarding the smoking issue after being caught wearing the oxygen while smoking. (No date provided)
-This review was completed and signed by the Nurse Manager.

Interview with the Supervisor in Charge (SIC) on 7/07/17 at 11:50 a.m. revealed:
-Staff had addressed this issue with Resident #1 in the past and he still went out with the oxygen tank to smoke.

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C 243	Continued From page 7 -She would tell him not to smoke with the oxygen nasal cannula and oxygen on, but he would argue and keep it on. -She could not supervise him everytime he went out to smoke. -She had not been instructed how to supervise the resident. -Staff reported that the resident refused to comply each time she tried to redirect him when he started out to smoke with the oxygen tank. -He would become verbally abusive when staff tried to redirect him. -Hospice staff had also educated Resident #1 on the dangers of taking the oxygen outside while he smoked. -Staff had notified the Administrator and the Nurse Manager. Request for hospice and home health notes related to the resident's smoking with oxygen on were not provided during the survey. Interview on 7/07/17 at 12:15 p.m. with the SIC revealed: -Everyone had spoken with the resident about the use of the oxygen and smoking since he had been admitted. -She was not aware of a procedure in place to supervise the resident each time he went to smoke to ensure safety, by not allowing smoking with the use of oxygen. Interview with the SIC on 7/07/17 at 4:22 p.m. revealed: -The facility's policy on problems with smoking inside the facility included a documented, verbal warning for the first incident; a write up for the second incident and notification of the Nurse Manager and Administrator; a third incident would require a fax to the Administrator and the resident	C 243		

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C 243	Continued From page 8 would be discharged. Telephone interview with the Nurse Manager on 7/07/17 at 12:28 p.m. revealed: -Staff had previously addressed the smoking issue. -The resident had been asked to leave the oxygen inside while he went outside to smoke. -The resident was told he could not smoke while using the oxygen. -There was a section in the contract the resident signed that prohibits smoking in certain areas. -Both Hospice and Home Health had addressed this issue with the resident and the resident's Primary Care Physician was aware of his smoking with the oxygen on per nasal cannula. -She was not aware staff were not supervising each time the resident went out to smoke. -The SIC would immediately have to start handing Resident #1 his cigarettes and lighter after removing his oxygen when going outside to smoke . -Starting immediately, the resident would be asked to comply or have to be discharged from the facility. -Staff were to document if resident did not comply and notify the administrator immediately. -The plan for now would be the SIC would give one cigarette to the resident at a time and smoking materials would be kept by the SIC and locked in the cart. -Staff would hand a cigarette and lighter to the resident after he had left his portable oxygen tank and nasal cannula tubing inside the building before he went to out to smoke. -Staff would supervise the resident while smoking to ensure the oxygen was not taken to the smoking area once the resident was there to smoke. -The staff would confiscate the lighter when he	C 243		

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C 243	Continued From page 9 was finished and back in the home. A telephone interview was attempted on 7/07/17 with the resident's Primary Care Physician but he was unavailable for comment. Observation of Resident #1 on 7/07/17 at 12:55 p.m. revealed: -Resident #1 approached the kitchen and asked the SIC for a cigarette. -The SIC handed the resident a cigarette and his lighter. -Resident #1 went to the door and removed his oxygen, left the tank inside and then went out onto the porch to smoke. -He returned from smoking at 1:01 p.m. and put on his oxygen. -The SIC collected the lighter from Resident #1. Interview on 7/07/17 at p.m. with the SIC and Resident #1's family member 7/07/17 revealed: -The SIC informed Resident #1's mother to give any cigarettes she purchases to staff to prevent the resident from smoking with his oxygen. -Resident #1's mother expressed understanding and agreed to this plan. Interview on 7/07/17 at 6:33 p.m. with the Nurse Manager revealed: -Resident #1 knew not to use the oxygen while smoking. -He had been having a very hard time recently regarding his medical status and had not been cooperative and was verbally abusive at times. -Staff should document all contacts with the physician and she thought staff had documented the contacts and any concern for the safety of not using oxygen while smoking. -There had not been a formal discharge pursued until this point.	C 243		

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C 243	Continued From page 10 -She would talk with the Administrator about possible 30 day discharge of the resident. -There was no information provided about a procedure in place about how staff were to have been supervising Resident #1's smoking with oxygen to protect the resident. _____ The facility failed to provide a system of supervision for Resident #1 based on assessed needs of repeatedly smoking while using oxygen, resulting in the resident placing himself and others in danger by smoking while using oxygen via nasal cannula and/or having the oxygen tank nearby while smoking. The facility's failure to supervise the use of oxygen when smoking was detrimental to the health safety and welfare of the resident and constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 7/11/17 revealed: -Cigarettes were to be given to the resident one at a time by the SIC and staff was to ensure the resident did not go out to smoke with the oxygen tank. -The lighter will also be held. -The resident's family member had been informed to turn over all cigarettes and lighters to staff. -If the resident was caught smoking with the oxygen, he will be discharged. -An immediate discharge will be in effect if another incident occurs. THE CORRECTION DATE OF THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 21, 2017.	C 243		

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C 256	Continued From page 11	C 256		
C 256	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the kitchen and food storage areas were protected from vermin and to ensure the stove/oven, refrigerator and refrigerator freezer in the storage room and dry storage closet next to the air handler were clean. The findings are: Observation on 7/07/17 at 9:45 a.m. of the dining area revealed: -A sticky fly strip was hanging from the ceiling with two flies attached to it. -It was hanging within one - two feet from the dining table where residents would have to go next to it to be seated at mealtime. Observation on 7/07/17 at 10:45 a.m. of the kitchen and food storage areas revealed: -The stove top had blackened burned on food ring on each glass stove top area. -The inside of the oven door was covered with dried on grease and food liquids that had an amber color. -There was greasy lumpy build-up on the stove range hood exhaust fan unit filter. -The wall behind the stove was had amber	C 256		

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C 256	Continued From page 12	C 256		

colored splatter marks.
-The ceiling near the stove had amber colored splatter marks.
-Under the sink was an open hole where the sink pipes came through.
-The hole was large enough for vermin to enter under the sink storage area.
-Another hole under the sink area on the right side and was large enough for vermin to enter.
-There was a thick build-up of gray dust on the slatted door metal 1 1/2 foot by 1 1/2 foot vent opening to the dry/canned food storage area where the facility air handler was located.
-The air handler inside of the the food storage area had two large thick air filters covered with a thick layer of gray dust.
-The microwave on the counter next to the stove was smeared with greasy fingerprints and inside were food splatters and particles.
-The ceiling had multiple areas of a beige speckled spots throughout the kitchen.
-The wall behind the stove top was splattered with grease and liquid food drips.
-On the edge of the counter next to the stove there was a two inch piece of molding missing with the wood under the molding showing on one side and a five inch piece missing on the left side.
-The dishwasher handle was missing with the two holes for the attachment exposed.

Interview on 7/07/17 at 10:50 a.m. - 10:53 a.m. with the supervisor-in charge (SIC) revealed:
-The owner of the facility building would not let the staff clean the stove top, oven door, refrigerators, including the storage refrigerator freezer in the garage storeage area and other areas with anything to remove the burned on food and dirt.
-They used mild soap and water and turned the oven onto "self clean" which did not get all of the

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C 256	Continued From page 13	C 256		

stuck on liquids.
-The grease filter had been replaced about 3 months ago but they needed changing again.
-The microwave was so bad she had to buy another microwave to use for the residents.
-The metal air handler vent in the slatted wood door to the the food storage closet was wiped down every so often but it was thick with dust again.
-The vent needed to be painted every three months by the handyman.
-The handyman also changed the filters on the air handler in the storage closet every three months.
-She said they needed changing at this time.
-The Administrator was not available that day but she was aware of all of these concerns because the SIC had mentioned them.
-She would have to tell the Nurse Manager who would tell the Administrator who would get the handyman to come in to change it again.

Observation on 7/07/17 at 11:10 a.m. of the refrigerator freezer in the storage area outside in the garage shed revealed:
-The outside of the freezer and refrigerator doors and sides were covered with a rust colored substance.
-The rubber gasket around the door was covered with the rust colored substance.
-The handles were discolored with a gray dirty substance.

Interview on 7/07/17 at 2:30 p.m. with the SIC revealed:
-The condition of the kitchen counter edge strips on the edges were missing and the dishwasher did not have a handle and was not able to be used since she started working here last summer.
-She had found a snake the room next to the kitchen and mice in the kitchen a couple of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 07/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	3524 DICKEY MILL ROAD MEBANE, NC 27302

(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
C 256	Continued From page 14 months ago. -They got into the kitchen and room next to the kitchen from the holes under the kitchen sink. -She was not aware of any openings in the walls outside of the facility. -The facility management knew about the problem and the exterminator was aware and was going to attend to the problem. -She had been told to put moth balls into the holes and she did this and there had not been any other vermin found since then by the exterminator. -The holes in the walls were to be repaired. -The wall holes are an ongoing problem in the facility. -The Administrator was out of town and unavailable for interview that day but she was aware of the problems. Interview on 7/07/17 at 6:30 p.m. with the Nurse Manager revealed: -She was aware of the kitchen equipment concerns such as the dishwasher and stove/oven clean in. -They would look for a stove and oven cleaner acceptable to the facility building owner. -She would ensure the areas of the storage closet in the kitchen such as the filers and the vent would be cleaned more frequently. -Staff were to clean on a daily basis and were to inform the Nurse Manage when areas such as filters needed to be replaced. -The Administrator was aware of the repair concerns but they were handicapped by the facility building owner's instructions for repair and deep cleaning -She was not aware of the vermin entering the facility and would send the handyman to repair holes and the exterminator to recheck the facility.	C 256		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 912	Continued From page 15	C 912		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents receive care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to supervison for a resident smoking while using oxygen. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide supervision of 1of 1 residents (#1) sampled resulting in the resident placing himself and others in danger by smoking outside of the facility while using oxygen. [Refer to Tag 0243 10A NCAC 13G.0901 (b) Personal & Supervision. (Type B VIolation).]	C 912		