

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL011277</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>06/27/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAND TERRACE FCH # 2</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>32 SMITH GRAVEYARD RD</b><br><b>ASHEVILLE, NC 28806</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| {C 000}                                                             | Initial Comments<br><br>The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow-up survey on June 27, 2018.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | {C 000}                                                                                             |                                                                                                                          |                                                                    |
| {C 140}                                                             | 10A NCAC 13G .0405(a)(b) Test For Tuberculosis<br><br>10A NCAC 13G .0405 Test For Tuberculosis<br>(a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.<br>(b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure 1 of 2 sampled staff (Staff A) was tested upon hire for tuberculosis (TB) disease with the two-step skin test in compliance with control measures adopted by the Commission for Health Services.<br><br>The findings are:<br><br>Review of Staff A's personnel record revealed:<br>-Staff A was hired as a Medication Aide (MA) on | {C 140}                                                                                             |                                                                                                                          |                                                                    |

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WOODLAND TERRACE FCH # 2</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>32 SMITH GRAVEYARD RD</b><br><b>ASHEVILLE, NC 28806</b>                      |  |                                                                    |
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| {C 140}                                                             | <p>Continued From page 1</p> <p>06/10/14.</p> <p>-There was documentation of a negative TB skin test dated 05/03/11.</p> <p>-There was documentation of a negative TB skin test dated 06/06/14.</p> <p>-There was no documentation of a two-step skin test in Staff A's personnel record.</p> <p>Interview with Staff A on 06/27/18 at 9:50am revealed:</p> <p>-She had worked for this employer since 2010.</p> <p>-She had worked in this facility since 06/10/14.</p> <p>-She had "numerous" TB tests since her original date of hire.</p> <p>-She did not know the reason there was no documentation of a two-step skin test in her record.</p> <p>Interview with the Administrator on 06/27/18 at 9:45am revealed:</p> <p>-Staff A had worked for him since 2010.</p> <p>-She had worked in this facility since 06/10/14.</p> <p>-There had been documentation of a TB skin test in Staff A's record from 2010.</p> <p>-Following the recent survey he had removed the 2010 TB skin test documentation because "it was old and I figured the other two [documented tests] were more current".</p> <p>-He was responsible for assuring all staff had a two-step skin test completed upon hire and documentation was maintained in staff personnel records at the facility.</p> | {C 140}                                                                       |                                                                                                                          |  |                                                                    |