STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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 Iredell County Department of Social Services conducted an annual, follow-up and complaint investigation survey on September 4-5, 2019.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 3 of 3 sampled residents with diet orders for a puree diet (Resident #4 and #7) and a mechanical soft ground meat diet (Resident #8). The findings are: 1. Review of Resident #4's current FL2 dated 08/15/19 revealed: -Diagnoses included chronic reflux, Alzheimer's disease and dementia. -There was an order for a pureed diet. Review of the lunch menu for 09/04/19 revealed the menu consisted of rosemary pork loin, broccoli florets, mushroom rice, dinner roll, margarine, and tropical fruit salad. Review of the facility's therapeutic diet list on 09/04/19 revealed Resident #4 was to be served a regular diet with pureed consistency and thin	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

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D 310	Continued From page 1 liquids. Observation of the lunch meal service on 09/04/19 at 12:00pm revealed: -Resident #4 was served ground pork, pureed zucchini, mashed potatoes, pureed bread, pureed mixed fruit and tea. -The pork loin would need to be pureed to a whipped consistency in a food processor to be safe for a resident on a pureed diet. -After prompting, the dietary staff removed the ground pork loin from the resident's plate. Review of the therapeutic diet menu for lunch on 09/04/19 revealed residents on a pureed diet should be served pureed rosemary pork loin with brown gravy, pureed broccoli florets, pureed mushroom rice, pureed dinner roll with margarine, and pureed tropical fruit salad. Review of the breakfast menu for 09/05/19 revealed the menu consisted of buttermilk pancakes, margarine, syrup and bacon. Observation of the breakfast meal service on 09/05/19 at 8:25am revealed Resident #4 was served non-pureed oatmeal, with whole intact oats, pureed pancake, pureed sausage and gravy, juice and water. Review of the therapeutic diet menu for breakfast on 09/05/19 revealed residents on a pureed diet should be served pureed buttermilk pancakes, pureed oatmeal cereal, pureed sausage patty, orange juice, milk, coffee or tea. Interview with the Dietary Manager on 09/05/19 at 8:30am and 8:45am revealed: -She was aware Resident #4 was served non-pureed oatmeal for the breakfast meal and	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

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D 310	Continued From page 2	D 310		

that the oatmeal did not have to be pureed.
-She contacted the District Manager and confirmed oatmeal did not have to be pureed.

Telephone interview with Resident #4's physician on 09/05/19 at 10:20am revealed:
-He could not remember Resident #4's current diet order.
-Serving foods not allowed on Resident #4's therapeutic diet would put her at risk of choking or aspirating.

Refer to interview with the Dietary Manager on 09/04/19 at 12:05pm.

Refer to interview with the Facility Administrator on 09/04/19 at 3:25pm.

Refer to observation of a new food processor on 09/04/19 at 4:00pm.

2. Review of Resident #7's current FL2 dated 02/19/19 revealed:
-Diagnoses included gastroesophageal reflux disease (GERD) and hiatal hernia.
-There was an order for a regular puree diet with nectar thick liquids and double portions.
-There was an order provide feeding assistance with meals.

Review of Resident #7's signed physician's orders dated 07/12/19 revealed an order for a regular pureed diet with nectar thickened liquids.

Review of the lunch menu for 09/04/19 revealed the menu consisted of rosemary pork loin, broccoli florets, mushroom rice, dinner roll, margarine, and tropical fruit salad.

Review of the facility's therapeutic diet list on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 310	Continued From page 3 09/04/19 revealed Resident #7 was to be served a regular diet; puree consistency, with nectar thickened liquids. Observation of the lunch meal service on 09/04/19 at 12:00pm revealed: -Resident #7 was served ground pork, pureed zucchini, mashed potatoes, pureed mixed fruit, pureed bread, and nectar thick tea. -The pork loin would need to be pureed to a whipped consistency in a food processor to be safe for a resident on a pureed diet. -After prompting, the dietary staff removed the ground pork loin from the resident's plate. Review of the therapeutic diet menu for lunch on 09/04/19 revealed residents on a pureed diet should be served pureed rosemary pork loin with brown gravy, pureed broccoli florets, pureed mushroom rice, pureed dinner roll with margarine, and pureed tropical fruit salad. Observation of the breakfast meal service on 09/05/19 at 8:25am revealed Resident #7 was served non-pureed oatmeal, with whole intact oats, pureed pancake, pureed sausage and gravy, nectar thick tea and water. Review of the therapeutic diet menu for breakfast on 09/05/19 revealed residents on a pureed diet should be served pureed buttermilk pancakes, pureed oatmeal cereal, pureed sausage patty, orange juice, milk, coffee or tea. Interview with the Dietary Manager on 09/05/19 at 8:30am and 8:45am revealed: -She was aware Resident #7 was served non-pureed oatmeal for the breakfast meal and that the oatmeal did not have to be pureed. -She contacted the District Manager and	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 310	Continued From page 4	D 310		

confirmed oatmeal did not have to be pureed.

Telephone interview with Resident #7's physician on 09/05/19 at 10:20am revealed:
-Resident #7 was on a pureed diet due aspiration pneumonia.
-Resident #7 should be served the correct diet.
-Serving foods not allowed on Resident #7's therapeutic diet would put her at risk of choking or aspirating.

Refer to interview with the Dietary Manager on 09/04/19 at 12:05pm.

Refer to interview with the Facility Administrator on 09/04/19 at 3:25pm.

Refer to observation of a new food processor on 09/04/19 at 4:00pm.

3. Review of Resident #8's current FL2 dated 06/24/19 revealed there was an order for a regular pureed diet with honey thickened liquids.

Review of Resident #8's signed physician's orders revealed:
-There was an order dated 08/26/19 for a mechanical soft diet with regular liquids.
-There was an order dated 08/26/19 to feed Resident #8 one on one slowly to avoid choking.
-There was an order dated 08/28/19 for a regular mechanical soft with ground meat diet.

Review of the lunch menu for 09/04/19 revealed the menu consisted of rosemary pork loin, broccoli florets, mushroom rice, dinner roll, margarine, and tropical fruit salad.

Review of the facility's therapeutic diet list on 09/04/19 revealed Resident #8 was to be served

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 310	Continued From page 5 a regular mechanical soft with ground meats diet; thin liquids and 1:1 feeding. Observation of the lunch meal service on 09/04/19 at 12:00pm revealed: -Resident #8 was served diced pork loin, zucchini, mushroom rice with gravy, pureed mixed fruit and tea. -The pork loin would need to be finely chopped with a knife or ground in a food processor to be safe for a resident on a ground meats diet. -After prompting, the dietary staff removed the diced pork loin from the resident's plate. Review of the therapeutic diet menu for lunch on 09/04/19 revealed residents on a ground meat diet should be served ground rosemary pork loin with brown gravy, sliced broccoli florets, mushroom rice, dinner roll with margarine, and ground tropical fruit salad. Attempted telephone interview with Resident #8's physician on 09/05/19 at 10:10am was unsuccessful by exit. Refer to interview with the Dietary Manager on 09/04/19 at 12:05pm. Refer to interview with the Facility Administrator on 09/04/19 at 3:25pm. Refer to observation of a new food processor on 09/04/19 at 4:00pm. _____ Interview with the Dietary Manager on 09/04/19 at 12:05pm revealed: -The cook was responsible for preparing texture modified meals. -She was responsible for checking their food to	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 310	Continued From page 6 ensure it was properly prepared prior to the food being served. -She did not observe the texture modified meals before they were served. -Texture modified meals were served incorrectly due to a broken food processor that overheated today at 11:30 am. -She did not notify the Administrator about the broken food processor because she thought it would work once it cooled. Interview with the Facility Administrator on 09/04/19 at 3:25pm revealed: -He was responsible for replacing the broken food processor. -He was not informed the food processor was broken until after food was served to residents during the lunch meal on 09/04/19. -Once the Dietary Manager informed him of the broken food processor, he immediately purchased a new one. -The Dietary Manager should have notified him as soon as the food processor became broken, so he could have replaced it and ensured food was correctly prepared. -The Dietary Manager was responsible for serving the correct diets. -He did not have a back up plan, as this had never happened in the past. -The meal could have been delayed instead of being served incorrectly. -An alternative meal should have been served. Observation of a new food processor on 09/04/19 at 4:00pm revealed the facility had replaced the broken food processor with a new processor.	D 310		
D 371	10A NCAC 13F .1004(n) Medication Administration	D 371		

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	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 371	Continued From page 7 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that medications were administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents related to 2 of 3 Medication Aides (Staff A and D) not using appropriate hand hygiene techniques and not wearing gloves when breaking a tablet in half. The findings are: 1. Observation of the noon medication pass on 09/04/19 from 11:00am to 11:41am revealed: -At 11:03am Staff A applied gloves and performed a finger stick blood sugar on a resident. -Staff A did not use hand sanitizer or wash her hands after removing the gloves. -At 11:09am Staff A administered medications to a second resident. -At 11:10am - 11:14am Staff A applied gloves, performed a finger stick blood sugar and administered insulin to the second resident. -Staff A did not use hand sanitizer or wash her hands after removing the gloves. -At 11:20am - 11:23am Staff A applied gloves,	D 371		

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	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 371	Continued From page 8	D 371		

performed a finger stick blood sugar and administered insulin to a third resident.
-Staff A did not use hand sanitizer or wash her hands after removing the gloves.
-At 11:26am - 11:30am Staff A applied gloves, performed a finger stick blood sugar and administered insulin to a fourth resident.
-Staff A did not use hand sanitizer or wash her hands after removing the gloves.

Observation of the medication cart on 09/04/19 at 11:30am revealed there was a bottle of hand sanitizer on the medication cart.

Interview with Staff A on 09/04/19 at 11:33am revealed:
-She had been trained to use hand sanitizer or wash her hands after administering medications to a resident.
-She had been employed in the facility for two years.
-She had received infection control training at the facility.

Review of Staff A's personnel record revealed she had received infection control training 02/20/19.

Refer to interview with the Administrator on 09/05/19 at 11:47am.

Refer to interview with the Nurse Consultant on 09/05/19 at 11:53am.

Refer to review of the facility's Infection Control Policy and Procedure.

2. Observation of the morning medication pass on 09/05/19 from 7:42am to 8:05am revealed:
-Staff D pushed a potassium chloride tablet from a medication bubble pack into a medication cup.

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	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 371	Continued From page 9 -Staff D picked up the tablet with her bare hands, broke the tablet in half, and placed it back in the medication cup to administer to a resident. Observation of the medication cart on 09/05/19 at 8:05am revealed there were gloves in the medication cart. Interview with Staff D on 09/05/19 at 8:06am revealed: -She had been employed in the facility for "about a week and a half". -She had received infection control training. -She had forgotten to wear gloves. Review of Staff D's personnel record revealed: -Staff D had received bloodborne pathogen training 08/21/19. -Staff D had completed the Medication Clinical Skills check list 09/03/19. Refer to interview with the Administrator on 09/05/19 at 11:47am. Refer to interview with the Nurse Consultant on 09/05/19 at 11:53am. Refer to review of the facility's Infection Control Policy and Procedure. _____ Interview with the Administrator on 09/05/19 at 11:47am revealed: -The Nurse Consultant or the facility's contracted pharmacy conducted the infection control training. -He did not know why the MAs had not used proper hand hygiene. -He expected the Medication Aides (MAs) to sanitize their hands between residents and wear gloves when appropriate.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D 371	Continued From page 10 Interview with the Nurse Consultant on 09/05/19 at 11:53am revealed: -She completed the Medication Clinical Skills checklist with each medication aide which included proper hand hygiene. -She gave each MA a card with proper hand hygiene printed on the card. -She did not know why the MAs had not used proper hand hygiene. Review of the facility's Infection Control Policy and Procedure revealed proper hand sanitizing should be performed immediately after the removal of gloves before touching other medical supplies intended for use on other persons.	D 371		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

(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
D932	Continued From page 11 supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to properly dispose of single-use equipment used to puncture skin, consistent with the federal Centers for Disease Control and Prevention guidelines on infection control, related to 1 of 3 sampled Medication	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D932	Continued From page 12 Aides (Staff A) disposing of three insulin flex pen needles into the garbage. The findings are: Observation of the noon medication pass on 09/04/19 from 11:00am to 11:41am revealed: -At 11:14am, Staff A administered insulin to a resident with a flex pen. -Staff A removed the flex pen needle from the flex pen, placed it in her gloved hand, and then removed the glove. -Staff A then placed the glove with the used flex pen needle into the garbage can on the side of the med cart. -At 11:23am, Staff A administered insulin to a second resident with a flex pen. -Staff A removed the flex pen needle from the flex pen, placed it in her gloved hand, and then removed the glove. -Staff A then placed the glove with the used flex pen needle into the garbage can on the side of the med cart. -At 11:30am, Staff A administered insulin to a third resident with a flex pen. -Staff A removed the flex pen needle from the flex pen, placed it in her gloved hand, and then removed the glove. -Staff A then placed the glove with the used flex pen needle into the garbage can on the side of the med cart. Observation of the medication cart on 09/04/19 at 11:00am revealed there was a sharps (device or object used to puncture or lacerate the skin) container, approximately half full, attached to the side of the medication cart. Interview with Staff A on 09/04/19 at 11:33am revealed:	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D932	Continued From page 13 -She had been employed in the facility for two years. -She had received infection control training. -She knew that sharps should be disposed of in the sharps container. Review of a New Hire Training Form dated 05/10/17 revealed Staff A had received training on bloodborne pathogens. Review of Staff A's personnel record revealed: -There was documentation that Staff A had received Infection Control Training on 02/20/19. -There was documentation that Staff A had completed the Medication Clinical Skills checklist 07/09/18. Interview with the Administrator on 09/05/19 at 11:47am revealed: -The Nurse Consultant or the facility's contracted pharmacy conducted the infection control training. -Staff received bloodborne pathogen training during general orientation. -He did not know why the Medication Aide (MA) had disposed of the sharps in the garbage. -He expected the MAs to dispose of sharps in a proper container. Interview with the Nurse Consultant on 09/05/19 at 11:53am revealed: -She had completed the Medication Clinical Skills checklist with each medication aide which included sharps disposal and infection control. -She did not know why the MA had placed the sharps in the garbage. Review of the CDC (Center for Disease Control and Prevention) guidelines for infection control revealed all needles and other sharps be placed in a sharps disposal container immediately after	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049015	A. BUILDING: _____ B. WING _____	R-C 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JURNEY'S ASSISTED LIVING	1942 VAN HAVEN DRIVE STATESVILLE, NC 28625

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D932	Continued From page 14 use. Review of the facility's Infection Control Policy and Procedure revealed: -Finger stick device (used to obtain a sample of blood) should be disposed of in a sharps container. -Flex pen needles were not listed. -All staff were required to follow the infection control policy.	D932		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled	D992		

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D992	Continued From page 15 substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff C) prior to hire. The findings are: Review of Staff C's personnel record revealed: -There was no date of hire. -There was no documentation that Staff C had completed a drug screen. Interview with Staff C on 09/05/19 at 10:11am revealed: -Staff C was the Dietary Manager. -She was a contracted employee. -She started working in the facility 02/12/19. -She knew she had completed a drug screen "around" the time she started working in the facility. -She did not know where the paperwork was. Interview with the Administrator on 09/05/19 at 10:32am revealed:	D992		

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D992	Continued From page 16 -The food service employees were contracted from another company. -He thought all the required paperwork had been completed prior to the staff working in the facility. -He knew staff were required to complete a drug screen. -The contracted company could not locate the drug screen paperwork.	D992		