Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001165	A. BUILDING: _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES MEMORY CARE	3810 HERITAGE DRIVE BURL, NC 27215

(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 conducted an Initial Survey on 02/17/22.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the environmental storage room, containing hazardous materials, was locked and not accessible to residents. The findings are: Observation of a spa room in the Special Care Unit (SCU) on 02/17/22 at 7:36am revealed: -The room did not have a lockable room. -Within the room were two rooms, a bathroom, and a shower/tub room. -In the bathroom, sitting on top of a shelving unit, there was a spray disinfectant labeled caution avoid contact with the eyes and skin. -In the shower/tub room, sitting on an open shelf, there were multiple bath gels products labeled	D 056	An in-service was conducted on 2/17/2022 to educate staff on the importance of keeping chemicals out of reach of residents and the doors to the laundry rooms locked. 2/17/2022 All disinfectants, bath gels, disinfectant wipes, air neutralizer, and personal care products were removed from the spa bathrooms in both households. On 2/17/2022 signs were posted on the laundry room doors in both households stating the rooms are to remain locked at all times. DON, Administrator, or Designee make daily rounds to ensure personal care and cleaning products are put away and doors to the laundry area remain locked as required. By 03/25/2022 the laundry room door will have a badge swipe access lock installed on the door. This type of lock will prevent the door from being able to remain unlocked and residents from accessing the room or any of the other rooms inside that area.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Sara Kepley | Administrator | 3-7-2022

Reviewed and acknowledged 03/07/22.
Kathy Gray

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D 056	Continued From page 1 external use only, do not ingest. Observation of another spa room in the SCU on 02/17/22 at 8:27am revealed: -There was a countertop that had multiple containers of disinfectant wipes labeled caution and avoid contact with the skin. -There was a spray bottle of air neutralizer sitting on an opened shelf was labeled danger, may cause an allergic skin rash. Interview with a personal care aide (PCA) on 02/17/22 at 9:52am revealed: -Each PCA was assigned to a specific hall but was expected to watch over all of the residents. -After breakfast, all the residents were routinely seated in the living room to watch television until it was time to attend chapel. -Residents who were able to ambulate used the toilet in the spa bath within the SCU. -The residents never went into the spa bathroom unattended. -Staff were aware of every residents' location at all times. -The laundry room door was always locked. Interview with another PCA on 02/17/22 at 10:12am revealed: -Staff were always observing the residents in the living room. -Access to the spa bathroom was monitored by staff. -There was usually staff in the nursing station and the spa bathroom was visible from that location. -She had never found a resident unattended in the spa bathroom. -The laundry room door was locked at all times. -The residents' laundry was routinely done by third shift staff.	D 056		

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D 056	Continued From page 2 Interview with a Registered Nurse (RN) on 02/17/22 at 10:21am revealed: -The residents used the whirlpool tub in the spa bathroom. -One of the residents had her hair styled in the spa bathroom every morning. -He did not post the picture of the toilet next to the spa bathroom door. -He did not know why the picture was posted next to the door. -He had never seen a resident who was unattended in the spa bathroom. -Staff were active on the floor and were attentive to the residents. -Staff were familiar with the toileting schedules and needs of the residents. -When the residents needed to use the bathroom, staff routinely took the residents to the bathroom in their rooms. Observation of a resident laundry room in the SCU on 02/17/22 at 8:12 am revealed: -The exterior door to the room was unlocked. -There were 5 interior doors within the room. -One of the unlocked rooms had a spray bottle of a cleaner sitting on the counter with warnings that included, causing eye irritation, being harmful if swallowed, and prolonged skin contact causing skin irritation. -There were multiple containers of germicidal surface wipes stacked on an open shelf. -A third unlocked room contained multiple containers of laundry products sitting on the counter; the containers were labeled avoid contact with eyes, and do not ingest. -A fourth unlocked room contained a storage shelf with multiple containers of cleaning products sitting on an open shelf. -There was also a bottle of degreaser sitting on the shelf with warnings, corrosive, causes skin	D 056		

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D 056	Continued From page 3 and eye burns. -There were other concentrated cleaners on the shelf. Second observation of the resident's laundry room on 02/17/22 at 9:36am revealed the exterior door and all interior doors remained unlocked. Observation of a second resident laundry room in the SCU on 02/17/22 at 8:57am revealed: -The exterior door to the room was unlocked. -There were 5 interior doors within the room. -There was a door with signage to keep the door locked at all times; the door was unlocked. -The room contained an open shelf with multiple bottles of bleach and other cleaning products. -The room also contained multiple bottles of concentrated cleaners sitting on the floor and attached to the wall dispensing unit. -A second unlocked room contained multiple containers of laundry products sitting on a countertop; the containers were labeled avoid contact with eyes and do not ingest. Second observation of the second resident's laundry room on 02/17/22 at 9:48am revealed the exterior door and all interior doors remained unlocked. Observation of the resident laundry room doors on 02/17/22 at 3:54pm revealed the exterior doors were labeled with signage the door must remain locked at all times and the exterior door was locked. Interview with a housekeeper on 02/17/22 at 9:24am revealed: -There was a named resident who had to be redirected because she might wander into other rooms.	D 056		

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D 056	Continued From page 4 -The door to the resident laundry area was supposed to be locked because there were chemicals in the area. -The interior doors were supposed to be locked in case a resident came through the exterior door. -The door should never be left unlocked. -The doors should always be locked to keep the residents safe. -A resident may drink the laundry detergent. -The door to the resident laundry was locked when she came in today, 02/17/22 and she left it locked. -The door to the interior doors was unlocked, she did not think to lock the interior doors since the exterior door was locked. -She did not know who had left the exterior door unlocked. Interview with a third PCA on 02/17/22 at 9:48am revealed: -There was a named resident who was known to wander in the hallways. -She had seen the resident laundry room unlocked, it was "hit or miss." -The room should be locked for resident safety. -The residents could get into the chemicals, drink something, or fall and get hurt. Interview with a fourth PCA on 02/17/22 at 9:53am revealed: -The resident's laundry room was supposed to be locked because there were cleaning products and she would not want the residents to "get hold of something." -Residents could accidentally spray something in their face or drink something. -She was not saying the residents would, but "you did not know what they would do, so you should keep them safe." -It was common sense the door should be locked.	D 056		

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D 056	Continued From page 5 -She had seen the door to the resident laundry unlocked before and had reminded the staff who were around, that the door needed to be kept locked. Interview with another RN on 02/17/22 at 10:04am revealed: -The resident laundry room was supposed to be locked because residents might go into the room. -There was a named resident who explored, and may walk in, but would come back out. -A resident could slip on spilled detergent or the resident could potentially drink the detergent. -The chemicals should not be accessible to the residents because the resident could spill them on themselves or try to drink the chemicals. -If there was a warning, keep away from children, then it should be kept away from residents with dementia as well. Observation of the women's restroom in the activity area of the facility on 02/17/22 at 1:20pm revealed: -The restroom was accessible to residents when they participated in activities. -The door did not have a lock. -There was an aerosol canister of spray disinfectant in each of the stalls of the bathroom. Interview with the Administrator on 02/17/22 at 10:32am revealed: -Third shift staff were responsible for washing the residents' clothes. -Sometimes the residents' family members washed the residents' clothes at the facility. -The laundry room doors were locked, and staff monitored access to the laundry area. -The chemical storage area door was locked to prevent the residents from accessing the chemicals.	D 056		

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D 056	Continued From page 6	D 056		
	-She was not aware the laundry room and chemical storage room doors were unlocked this morning. -She checked the doors periodically. -The only time the doors were open was when the housekeeping staff was moving the housekeeping cart through the doors. -She was concerned the residents could sustain chemical burns if they accessed the chemicals. -There were two residents who wandered on the SCU; they wandered in the context of looking for their rooms. -Neither resident had ingested any harmful substances. -The residents lacked the cognitive ability to know what could potentially hurt them. Interview with the Director of Nursing (DON) on 02/17/22 at 10:32am revealed: -Doors were locked and housekeeping chemicals were properly stored for the safety of the residents. -The chemicals were dangerous to the residents. -She did not want the residents to consume or misuse any harmful chemicals. -If chemicals got into the residents' eyes, mouth, nose, or on their skin, it could result in irritation. -She had the same concerns regarding the storage of laundry chemicals. -She did not want the residents to have access to the laundry and chemical storage rooms. -She periodically checked the doors. -She did not know the laundry room and chemical storage room doors were unlocked this morning. -She expected housekeeping staff to keep the doors locked. -Items that should be restricted from children should likewise be restricted from the residents in a dementia unit out of concern for their safety. -Most of the personal care products used in the			

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D 056	Continued From page 7 facility were non-toxic but could cause problems if misused by the residents. -She expected sprays to be kept away from the residents, either stored on the housekeeping cart or in a locked cupboard.	D 056		