	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		HAL049010	B. WING		03/0	4/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CROWN	COLONY		MERCIAL DF VILLE, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
D 000	Initial Comments		D 000				
	The Adult Care Licensure Section conducted an annual survey on March 3-4, 2015.						
D 079	179 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings		D 079				
	10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.						
	This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a clean, orderly and uncluttered environment that was free of obstructions and hazards throughout the facility.						
	The findings are:						
	on 3/3/15 from 9:25 revealed: -At 9:40am in the band the shower floor on the floor and sid-At 9:47 am in the bathe wastebasket was used pull up, there splatters visible on commode, and the on the right side of	pathroom adjoining room A6, as overflowing and contained a were yellow and brown the upper rim of the the bottom portion of the shower the commode was dirty with a and ants were seen crawling up					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL049010	B. WING		03/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CROWN	COLONY		MERCIAL DE			
			VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 079	Continued From pa	ge 1	D 079			
	-At 10:03am in the the commode had a appeared to be feed commode seat, the and contained a use flecks in the bottom hand side near fauct strongly of urineAt 10:16am in the lithe wastebasket was used pull up, the coyellow substance in of red substance or and the shower floor on the floor and side.  Observation on 3/3/closet door around was dirty and in need to be substance or and the shower floor on the floor and side.  Observation on 3/3/closet door around was dirty and in need to be substance or and the shower floor and side.  The ceiling fan on thick black dust and protruded down and socket where a light installed.  There were thick coeiling of the porch. The ceiling fan on of dust.  There were cigaret the floor.  There were ashes residents had put or substance or and the shower ashes residents had put or substance.	bathroom adjoining room A4, a brown substance which es on the back of the wastebasket was overfilled ed pull up, the sink had brown and gray residue on right cet, and the room smelled bathroom adjoining room B1, as overflowing and contained a mmode had streaks of a the bowl, the sink had specks in the left side of the faucet, or had gray colored soap scumes of the shower.  In at 10:15 am revealed the the door handle in room C4 ed of cleaning.  In at 11:29 am on the sining the main dining room the right side was coated in a dia single electrical wire dexposed from the light the bulb should have been obwebs visible around the the left side had a light coating the butts and ashes visible on visible in the windowsill where				

Division of Health Service Regulation

-At 9:45am, in the bathroom adjoining room B5

STATE FORM P3R911 If continuation sheet 2 of 13

DIVISION	of Health Service Re	guiation	ı		ı	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL049010	B. WING		03/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	-	
TV WIL OF T	NOVIDER OR OUT FIER		MERCIAL DF			
CROWN	COLONY		VILLE, NC 2			
			1			
(X4) ID		TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
D 079	Continued From pa	go 2	D 079			
D 019			D 07 9			
		eared to be black and brown				
		ottom suction cups of a clear				
		ottom of the shared resident's				
	shower.					
		pathroom adjoining room B7				
		o scum coating the bottom				
		ared resident's shower.				
		bathroom adjoining room B8,				
		o scum coating the bottom sident's shower, there was a				
		cking to the bowl of the				
	commode and ther	e were gray and yellow				
		3 inches wide above and				
		dle to the bathroom.				
		common shower room on C				
		of room C1, dirt tracked on the				
		de area and in between the				
	shower and bathtub	, the shower had a black				
	substance in the bo	ttom 3 inches by 2 inches				
	near the drain, and	the bathtub had thick ring of				
	soap scum and hair	r.				
		w with eleven residents on				
		evealed the following				
	comments:	and a data dila analysis and a				
		ents stated housekeeping				
	cleaned their bathro					
		ekeeper and she works very oom is] not cleaned often				
		e housekeeper doesn't work				
		ore than she can do."				
		inion, these bathrooms should				
		ay. We generally only get them				
	cleaned once a wee					
		lood job [with housekeeping] I				
	, , ,	e bathroom once a weeknot				
		e had a lot of trouble with				
	housekeepers, they					
		here. They clean my				
		, but no more than every other				

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 3 of 13

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	- COMPLETED
HAL049010 B. WING	<b>03/04/2015</b>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	·
291 COMMERCIAL DRIVE	
CROWN COLONY MOORESVILLE, NC 28115	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)  (X5) COMPLETE DATE
day." -"All they ever do for me is put toilet tissue out, soap, and paper towels. They dust my floor. The last time it was so dusty [the dust] was flying up. It's been a week since [housekeeping] last did the floor. Hardly ever cleans the bathroom every one to two weeks if that." - The housekeeper tries to clean the bathroom every day On the weekend the regular staff clean the rooms if they are dirty Sometimes the house keeper is not able to get to all the rooms but will get them the next day The housekeeper does work on weekends sometimes.  Interview with the Housekeeper on 3/4/15 at 9:50am revealed: - She worked 8 hours a day, 5 days a week, and was usually off Saturday and Sunday Every now and again she would get a day off during the week and would work Saturday instead She stated daily she emptied the wastebaskets for all the residents, swept all the residents rooms, and cleaned all the bathrooms everyday She stated she mopped the entire facility every other day "Every now and again, I wipe the dressers off." - She stated when cleaning a bathroom she would "wipe out the sink, wipe off the mirrors, wipe off the toilet, and spray and wipe the shower." - She stated the common bathrooms were cleaned daily and included cleaning the sinks, mirrors, commode, and emptying the wastebaskets She stated she was only responsible for housekeeping duties and did not perform any	

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 4 of 13

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
			B. WING			
		HAL049010			03/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S MERCIAL DF	STATE, ZIP CODE		
CROWN	COLONY		VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 079	Continued From pa	ige 4	D 079			
	Confidential intervies 3/3/15 and 3/4/15 re-There are some reafter the housekeep. The residents will bathrooms are dirty.  Interview on 3/4/15 Aide revealed the operformed were occlogged toilet, wipin resident wastebask.  Interview with the A 11:30am revealed: -The housekeeper -She was expected out of the four halls all of them when she	ew with two staff members on evealed: esidents who dirty their rooms per cleans them. not tell us when their //.  at 10:35am with a Medication only housekeeping tasks they casionally unstopping a grup a spill, or emptying tets.  dministrator on 3/4/15 at worked 40 hours a week. to completely clean two halls a day, but "She's trying to get				
D 310	smoking porch, but resident's had beer Another covered snaway from the build smoking porch was summer.  10A NCAC 13F .09 Service  10A NCAC 13F .09 (e) Therapeutic Did (4) All therapeutic supplements and the supplements and the supplements and the supplement supple	due to extreme weather, a allowed to still use it. moking area was provided ling for the resident's use. The sto be torn down over the 04(e)(4) Nutrition and Food 04 Nutrition and Food Service ets in Adult Care Homes: diets, including nutritional nickened liquids, shall be by the resident's physician.	D 310			

6899

Division of Health Service Regulation STATE FORM

P3R911 If continuation sheet 5 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			71. 501251110.			
		HAL049010	B. WING		03/0	4/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROWN	COLONY		MERCIAL DF VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
D 310	Continued From pa	ige 5	D 310			
	review, the facility f with a physician's o	ion, interview, and record ailed to assure 1 of 1 resident order for chopped meat was ed at the appropriate				
	The findings are:					
	revealed: -Diagnoses include ventriculomegaly, o disease, schizophre -A physician's order chopped meatsA physician's order used to stimulate a times a day with me -The resident was of	documented as intermittently nbulatory, and incontinent of				
	revealed: -The resident was of extensive assistant bathing, dressing, a	documented as totally				
		ty's therapeutic diet list on sident #2 was listed as a nopped meat.				
	Review of the facilit for lunch on 3/3/15 -3 oz. Salisbury ste -1/2 c. of noodles -1/2 c. vegetable m -1 wheat roll/bread	ak				

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 6 of 13

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL049010	B. WING		03/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CROWN	COLONY		MERCIAL DE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
D 310	Continued From paragrane -1/2 c. sherbet -1 c. milk -1 c. beverage of che Observation of Reson 3/3/15 from 11:4 revealed: -At 11:52am, the resteak which had be -The Salisbury steat consistencyThe resident receivassistance by staffStaff cut the reside fork into slightly sm the resident, however not at chopped contact contact the resident did not chewing or swallow observationThe resident had contact the reside	ge 6  noice ident #2 during the lunch meal 0am through 12:15am sident was served Salisbury en cut up in bite size pieces. k was not a chopped wed one on one feeding ent's Salisbury steak up with a aller pieces as they fed it to the consistency still was sistency. Of appear to have any trouble ing during the meal ensumed 75% of the the end of the meal.  Sook on 3/3/15 at 12:14pm osed to cut up [Resident #2's] why."  Medication Aide on 3/3/15 at [Resident #2] won't eat unless She won't chew anything."  y's posted regular diet menu 5 revealed: onion soup ackers chicken sandwich	D 310	DEFICIENCY)		

-1 c. milk

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 7 of 13

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL049010	B. WING		03/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CROWN	COLONY		MERCIAL DF VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
D 310	Continued From pa	ge 7	D 310			
	-1 c. beverage of choice					
	Observation of Resmeal on 3/3/15 from revealed:  -At 5:02pm, the reschicken sandwichThe piece of grilled been cut up by the chickenThe grilled chicker not chopped consistence by staffStaff cut the resident receivassistance by staffStaff cut the resident slightly smaller piece resident, however the chopped consistenceThe resident did not chewing or swallow observationThe resident had concident off the bun.  Interview with the Concept cause I do with. The person fersmaller." -The Cook was unausually prepared in correct consistency.	ident #2 during the supper in 4:45pm through 5:15pm dent was served a grilled dent was served a grilled dent was served a grilled dent was served to the resident was tency. We do no on one feeding ent's grilled chicken breast into the est as they fed it to the est as they fed it to the econsistency still was not by. Out appear to have any trouble ing during the meal ensumed 100% of the grilled by the end of the meal. Hook on 3/3/15 at 5:05pm est up the best I can with on't have anything to chop it up ending her cuts it up even the ware chopped meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the control of the meat was a food processor to obtain the ending the end of the ending the ending the ending the end of the end				
	3/3/15 at 5:10pm re swallow, I think she soft she doesn't usi	cond Medication Aide on evealed "[Resident #2] can just doesn't have teeth. If its cally have problems. It's not chew it, it's because she w it."				

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 8 of 13

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
,	o. co20		A. BUILDING:	A. BUILDING:		
		HAL049010	B. WING		03/0	4/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CROWN	COLONY		MERCIAL DE			
	0.18.44.57.4.074		VILLE, NC 2		011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 310	0 Continued From page 8		D 310			
	5:12pm revealed "[ for her in quarters. when I feed it to he Interview with the F	Resident Care Coordinator				
	(RCC) on 3/3/15 at 5:20pm revealed: -"That's what we've always done to cut up [chopped meat consistency] with fork and knife." -"We just use the term chopping it up." -"She needs it cut up because she can't cut the meat herself." -The RCC was unaware if the resident's physician was aware what the facility did to prepare					
		Resident #2, but she stated with resident's physician.				
		n's order for Resident #2 dated resident's diet was changed h cut-up meat.				
	physician's office of that the physician for	v with Resident #2's n 3/4/15 at 8:41am revealed elt meat cut-up with a knife otable for the resident.				
	11:30am revealed: -"Chopped meant of do any other diets." -"We discharge res-"Its too complicate	dministrator on 3/4/15 at cut-up meat because we don't idents with different diets." d trying to handle other diets." take residents with other				
D 317	10A NCAC 13F .09	05 (d) Activities Program	D 317			
	10A NCAC 13F .09	05 Activities Program				

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 9 of 13

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7t. Boilebiito.			
		HAL049010	B. WING		03/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CROWN	COLONY		MERCIAL DF VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 317	Continued From pa	ge 9	D 317			
	(d) There shall be a variety of planned ginclude activities the physical interaction creative expression learning of new skill exclusively for residexempt from this refacility can demons resident's involvem Examples of group dancing, games, exparties, discussion council meetings, bappreciation, review spelling bees.	a minimum of 14 hours of a group activities per week that at promote socialization, , group accomplishment, a, increased knowledge and ls. Homes that care dents with HIV disease are equirement as long as the trate planning for each ent in a variety of activities. activities are group singing, cercise classes, seasonal groups, drama, resident book reviews, music of current events and				
	This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure at least 14 hours of planned group activities were provided each week that promoted socialization and physical interaction for the residents residing in the facility.					
	The findings are:					
	of March 2015 reversery Sunday was 9:30 am through 12 through 7:30 pmEvery Monday was shopping 1:00 pm trevery Tuesday was pm through 8:00 pm through 8:00 pm through 2:00 pm through 1:00	documented as church from 2:00 noon, and 6:00 pm s documented as bank / hrough 4:00 pm. s documented as library 6:00 n. was documented as bank / hrough 4:00 pm, and pet				

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 10 of 13

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL049010	B. WING		03/0	4/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CROWN	COLONY		MERCIAL DF VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 317	games 9:00 am thro-Every Friday was on shopping 1:00 pm to Every Saturday was pm through 2:00 pm.  During the survey on activities were on activities were on the End of the End	ough 11:00 am. documented as bank / hrough 4:00 pm. as documented as bingo 1:00 m.  lates of 3/3/15 through 3/4/15 bserved being done.  facility activity book revealed: eled shopping list with resident in residents names with no expe of activity. End bingo with some residents are with three staff members are the dog on Wednesday and not been in a while. In residents going out to the infrom the outside to do bingo eek. The library was a room in the books for residents to look at. It in the residents who will not it ies. The groups come into the facility into are rude to them. The residents will not it is are rude to them. The residents will not it is are rude to them. The residents will not it is are rude to them. The residents will not it is a resident wi	D 317			

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 11 of 13

ווטופועום	of Health Service Re	guiation				
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
				<del> </del>		
		HAL049010	B. WING		02/0	4/2045
		HAL049010	B. W(0		03/0	4/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		291 COM	MERCIAL DE	RIVE		
CROWN	COLONY	MOORES	VILLE, NC 2	28115		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEI ICIENCI)		
D 317	Continued From pa	ge 11	D 317			
	"Mo only have one	a activity and that's hings. One				
		e activity and that's bingo. One comes in on Saturday's to do				
	[bingo.]"	comes in on Saturday's to do				
		ce a week, do arts and crafts				
	sometimes"	ce a week, do arts and crarts				
		th [names of two community				
		bingo 1-2 times a week ".				
		t going to the library on the				
		s scheduled on the activity				
	calendar, another re	esident stated "We didn't go				
		ped going to the library years				
	ago".					
	-"We have bingo ar					
		he resident had any recent				
		to the library the resident				
	love to read."	ce I've been here, but I used to				
		asked about what activities				
		the day at the facility one				
		"Nothing much. They really				
		igs when they offer something.				
	I don't play bingo."	.gg.				
	-Another resident w	as asked about what activities				
	were offered and th	e resident stated "They have				
		s that I've seen. We have				
		ay, Wednesday, and Friday's."				
		at is on the activity calendar.				
	-They had never be					
	-They would like to					
		money there is no use to go				
	shopping"They would like to	do crafts				
	-Occasionally they					
	-Prizes in bingo are					
		anything else if it was				
	available.	, <u>-</u>				
		dar is a lie. We don't do				
	anything on the cale					
	-The activity calend	ar is the same every month.				
		we might go to Carowinds				

Division of Health Service Regulation

STATE FORM P3R911 If continuation sheet 12 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL049010	B. WING		03/0	4/2015
NAME OF PROVIDER OR SUPPLIER STRE		STREET ADI	ADDRESS, CITY, STATE, ZIP CODE			
CROWN COLONY 291 COMMERCIAL DRIVE MOORESVILLE, NC 28115						
PREFIX (EACH DEFIC	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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	SHOULD BE COMPLETE	
this summer""It would be n -There is not n -They would no -They liked to Interview with 11:30am revea -She was the f responsible for -"We have a p - "Our activity p bingo, arts and a month for bin -There is a great od yoga with residents"We have a g local churches -When asked a in the hallway a I haven't looke -"I wasn't awar the schedule, I the library in th problems."	Continued From page 12 this summer""It would be nice to have things to do"There is not much to do at the facility -They would not do anything if it was offeredThey liked to stay by themselves.  Interview with the Administrator on 3/4/15 at 11:30am revealed: -She was the facility's Activity Director and responsible for activities"We have a pretty good activities program." - "Our activity program includes pet therapy, bingo, arts and crafts, Girl scouts come one time a month for bingo"There is a group who is going to start coming in to do Yoga with the Traumatic Brain Injury residents"We have a great support system through the local churches in the community." -When asked about the activity calendar posted in the hallway she stated "Who did the schedule? I haven't looked at it I just told [the staff] to do it""I wasn't aware going to the library was still on the schedule, but we have taken the residents to the library in the past and had to stop because of problems." -We are planning on starting the library activity		D 317			

6899

Division of Health Service Regulation STATE FORM

P3R911 If continuation sheet 13 of 13