STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		03/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	-
CHINA GR	OVE RETIREMENT CEN	TER	JTH MAIN STRE		
		CHINA G	ROVE, NC 2802		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
	Annual survey on Mar	sure Section conducted an rch 18, 2015, March 19, ference via telephone on			
D 056	10A NCAC 13F .0305	(f)(4) Physical Environment	D 056		
	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: TYPE B VIOLATION Based on observation and interviews, the facility failed to assure cleaning agents used by 2 residents (Resident #4 and #5) were stored in a separate locked area when not in use and monitored by staff and were stored in a resident's room (Room #102) which could be hazardous if ingested or inhaled.				
	The findings are:				
	of a male cleaning 7 t room using a white qual label and a white clea	15 at 8:45 am and 12:35 pm ables in the residents' dining part-size spray bottle with no ning cloth. at 12:35 pm with Resident			

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) D A. BUILDING: C			
			R WING	B. WING		
		HAL080020	B. WING		03	3/20/2015
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHINA GI	ROVE RETIREMENT CEN	ITER 1114 SOL	UTH MAIN STREET	•		
OTHINA O	COVE RETIREMENT SER	CHINA G	ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 056	Continued From page	e 1	D 056			
	gives me something and the cleaned the table room after each mea and the substance in the bottle contained "a litage and the contained to supplies to use when and been volunted months. Review of the current Resident #4 revealed the was admitted to and the clean contained the conta	f the facility. In the facility because "it to do." It is in the residents' dining learn the residents' dining learn the facility because "it to do." It is unmarked white quart-size the bleach and water." It is in the residents' dining learning. It is in the facility on facility on 7/30/14. It is the facility on 7/30/14. It is ded pancreatitis, Failure to puctive Pulmonary Disease, lost Traumatic Stress				
	from Resident Room on 03/18/15 at 9:00 a -The door to the laun unlockedA white quart-size sp bleach" on the bottleAn unmarked white containing a yellow lineral ware of a multi-purpoblack on the bottleA white unlabeled que containing a liquid the agent with the trigger -All of the quart-size spense.	dry room was open and bray bottle marked "3rd shift quart-size spray bottle quid. bray bottle marked with the bose cleaning agent written in luart-size spray bottle at smelled like a cleaning				

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 2 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) I			
		HAL080020	B. WING		0;	3/20/2015
	ROVIDER OR SUPPLIER	1114 SO	DDRESS, CITY, STATE			
CHINA GE	ROVE RETIREMENT CEN	ITER CHINA G	ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 056	Continued From page	e 2	D 056			
	laundry room.					
	#5 who resided in Ro -"We have assigned -He used the washer laundry room to wash -Staff would assist hir preferred to do it him Further interview on 0 #5 revealed: -There were six built- storageEach resident had tw -The first closet on th closet" where anothe Room #102 kept clea helps clean" the facili -"Staff knows that the -"They know that it is	laundry days". and dryer located in the his clothes. m with his laundry, but he self. 03/19/15 11:35 am Resident in closets for residents' wo closets. le left was "the chemical or resident who resided in aning supplies "because he				
	-"There are some people that live here that you wouldn't have chemicals in their rooms." -"No one has bothered the chemicals."					
	-He was admitted to a -A current FI-2 signed including schizophrer (mild), seizure disord injuryReview of the care procumentation the results.	of Resident #5 revealed: the facility on 10/29/14. d 11/25/14 with diagnoses nia, alcohol use disorder er, and traumatic brain blan dated 10/29/14 revealed esident was sometimes				
	am revealed: -A built-in closet loca	etful. n #102 on 03/19/15 at 11:40 ted in the first position in a n the left in Resident Room				

Division of Health Service Regulation

STATE FORM STATE FORM SHEET 3 of 37

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		HAL080020	B. WING		03/20/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CHINA GE	OVE RETIREMENT CEN	1114 SOUT	TH MAIN STRE	ET		
	OVE RETIREMENT SER	CHINA GR	OVE, NC 2802	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 056	Continued From page	e 3	D 056			
D 030	#102 that was unlock -The built-in closet hat the closet door, but di -A two-thirds full 1.12 general purpose clear located at the bottom The manufacturer's w May react with bleach other household clear gases (2) Avoid conta clothing (3) Causes m irritation occurs, get m -Two quart-size manu non-aerosol air fresh -One bottle of air fres three-fourths fullOne bottle of air fres one-eighth fullPrecautionary statem air freshener included and skin irritation. (2) swallowed. (3) Inhala cause respiratory irrit eyes, skin or clothing -A white quart-size sp with a liquid and the r cleaning agent and di bottle in black inkA supply of white cle -A supply of brown pa -Four empty white qu letter "B" written on it. Second interview on the Resident #4 revealed -The Resident Care E	ed. Id a latch on the right side of id not have a lock. If gallon size container of a ning agent and disinfectant of the closet. It warning label included: (1) in-containing products or ners to produce hazardous act with skin, eyes, or nild skin irritation - If skin nedical advice. If acturer's spray bottles of a gener and deodorizer was thener and deodorizer was thener and deodorizer was thener and deodorizer was thener and deodorizer was the harmful if tion of product mist may ation. (4) Avoid contact with the two bottles of a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose is infectant written on the maning clothes. If a general purpose				
	shift staff who cleaned	I daily as well as for third d at night. closet, but staff lets me				

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 4 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
			71. BOILBING			
		HAL080020	B. WING		03	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
CUINA CE	DOVE DETIDEMENT CEN	1114 SOU	TH MAIN STREET	•		
CHINA GI	ROVE RETIREMENT CEN	CHINA GI	ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	dining room as well a floors of the facility. -The RCD was to obt -None of the resident misuse the chemicals the facility that might	cais to clean tables in the sis to clean toilets and the sain a lock for the closet. It is of Room #102 would so, but there were residents in "if they could get to it."				
	-The third shift staff obtained cleaning supplies from the closet in Resident Room #102 because "the chemical closet is locked" and they did not have a key. Further interview with Resident #4 on 03/19/15 at 12:32 pm revealed: -The white quart bottles in his closet were ones that had previously contained cleaning chemicals and he reused the bottlesHe took cleaning supplies out of his closet daily for third shift because they did not have a key to the locked cleaning supply closet of the facility.					
	revealed: -She had told a reside #102 that he could keen in his closet a few money. She was unaware of supplies that were stern #102The cabinet was unlended a lock that see the supplies that a lock that see the supplies was unlended.	f the amount of cleaning ored in Resident Room ocked during the day while ered to clean in the facility. She put on the closet daily illty, but she did not open the				
	-The third shift staff w the facility, but did no closet. -She was aware that	vere responsible for cleaning of have a key to the chemical Resident #4 removed m his closet for third shift				

Division of Health Service Regulation

STATE FORM STATE FORM SHEET 5 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '			(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		COIVII L	LILD
		HAL080020	B. WING		03/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHINA GF	ROVE RETIREMENT CEN	ITER	TH MAIN STRE			
	0.11.11.15.4.07		OVE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 056	056 Continued From page 5		D 056			
	staff to use each night-She locked the clear room each day at the look in the closet in Rit each day. -She was not aware to containing chemicals. -Residents used the litheir clothes. -She would remove the immediately and place chemical closet. Observation on 03/19 resident and the RCE	ot. ning supplies in the medicine end of her shift, but did not soom #102 when she locked that there were bottles in the laundry room. aundry room for washing the bottles with chemicals the them in the locked 10/15 at 12:35 pm revealed a to removed the chemicals to set in Room #102 and				
	Interview on 03/19/15 at 12:50 pm with the Corporate Administrator revealed: -She was unaware that chemicals were stored in an unlocked closet in Resident Room #102A resident in Room #102 "volunteers to clean" and performs tasks such as cleaning the tables in the dining room, sweeping, and moppingThe facility's policy was to have all chemicals in a location that was locked and not located in a resident's roomThe facility did have residents with mental health diagnosis who could be at risk for misusing chemicalsThere had been no incidents with residents misusing chemicals that were stored in Resident Room #102.					
	The facility provided to Protection on 04/03/1 -All chemical contains immediatelyAll chemicals are loc	5:				

Division of Health Service Regulation

STATE FORM STATE FORM SHEET 6 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	HAL080020		B. WING		03/20/2015
	ROVIDER OR SUPPLIER	TER 1114 SOUT	RESS, CITY, STA H MAIN STRE DVE, NC 2802	ET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE
D 056	timesThe RCD will monito chemical closet is loc CORRECTION DATE	will remain locked at all r daily to ensure that the ked.	D 056		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;		D 074		
	This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls, ceilings, and floors were clean and in good repair in 2 of 10 residents' rooms (Room #103 and #108). The findings are: Observation of the facility layout out during the initial tour on 3/18/15 revealed the facility had 2 halls, [Hall A (Rooms #101, #102, #103, #104) and Hall B (Rooms #105,#106, #107, #108, #109, #110)], a dining area with alcove (dayroom), and a lobby/foyer. A. Observation of Room #108 on 3/18/15 at 9:30 am during facility tour revealed: - Two residents resided in the room. - Directly overhead at the entry door there were 2				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 7 of 37 XBF311

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
HAL080020		B. WING		03	03/20/2015	
	ROVIDER OR SUPPLIER	TER 1114 SOU	DDRESS, CITY, STATE ITH MAIN STREET ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 074	a partial ceiling tile m flexible duct pipes, a metal pan (approxima 4 inches deep) Five additional ceilir located throughout th Interview on 3/18/15 residents residing in I - He had resided at tr - The ceiling tiles had months due to repair heating/cooling unit fo - The temperature in for the time the ceiling - Staff were aware of nobody had come the - He thought the stair from the leaking drair Interview on 3/19/15 resident residing in ro - The ceiling tiles had months The missing tiles dio - He had not experier the room temperature been missing. Interview on 3/18/15 Management Compa - The ceiling tiles wer tiles about a year ago - The facility did not h - The heating/cooling the damaged tiles be were made The heating/cooling	issing, exposing multiple heating/cooling unit and a ately 24 inch by 72 inch and ately 25 inch a	D 074			

Division of Health Service Regulation

STATE FORM STATE FORM SHEET 8 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	CONSTRUCTION	I ` '	(X3) DATE SURVEY COMPLETED	
			_				
		HAL080020	B. WING		03/	20/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
CHINA GF	ROVE RETIREMENT CEN	TER	TH MAIN STRE				
			OVE, NC 2802				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 074	Continued From page	8	D 074				
	contacted a few mont the heating/cooling ur repaired. - The ceiling tile comp contacted by the build	-					
	Interview on 3/19/15 at 4:00 pm with the building owner/Administrator revealed: - He had hired a ceiling contractor to replace all the building's ceiling tiles last year following the survey by Construction. - The ceiling tiles were fire rated and had to be custom installed by a contractor. - The facility notified him that the heating/cooling unit needed repairs and ceiling tiles were damaged a few months ago (not sure of the exact date). - The facility had requested the ceiling tiles be replaced, but he had experienced problems contacting the original contractor. - He stated he had spoken with the contractor, but was not aware the repairs had not been completed. - He stated he would contact the contractor again today (3/19/15).						
	shift medication aide - The ceiling tiles in refor 4 to 5 months The residents had nother missing tiles She felt certain man missing tiles. Interview on 3/19/15 a	oom #108 had been missing ot complained to her about agement was aware of the					

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 9 of 37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		HAL080020	B. WING	03	03/20/2015	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	E, ZIP CODE		00.
		1114 SOU	TH MAIN STREET	· [
CHINA GE	ROVE RETIREMENT CEN	TER	ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 074	Continued From page	9	D 074			
	of the missing tiles, but she had not requested for maintenance to replace the tiles. Interview on 3/19/15 at 4:45 with the Resident Care Director (RCD) revealed: - She was aware the ceiling tiles were missing from room #108 The ceiling tiles had been missing for several months The heating/cooling repair company was at the facility on 1/27/15, but did not mention the tiles The Corporate Administrator knew about the missing ceiling tiles and was working on getting them replaced No residents had complained to her about stained or missing ceiling tiles.					
	B. Observation of Ro am during facility tour	oom #103 on 3/18/15 at 9:20 revealed:				
	-Four residents reside	ed in the room.				
	tiles located overhead	24 inch by 48 inch ceiling d and in front of the double				
	sink area in the residents' room had dark brown stains. -One approximately 24 inch by 48 inch ceiling tile located on the right far ceiling with a dark brown stain.					
	-Measurements of the was approximately tw	e stains for each ceiling tile vo tiles with a stain 6 inches vith a stain 3 inches in				
	diameter and one tile	with multiple small brown				
	stains that were approximately one-half inch in diameter.					
	-Two of 7 fluorescent constructed to contain stains inside the cover	n 4 bulbs) had dark brown				
	-Measurements of the each light fixture cove	e dark brown stains inside er was approximately one				
	cover with a 24 inch the with a 12 inch by 4 in	by 9 inch stain, one cover ches.				

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 10 of 37

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPLETED	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 074 Continued From page 10 -A double sink with a cabinet measuring approximately 5 feet in width with dark brown stains on the bottom wooden baseboard with the stains extending the length of the cabinet measuring approximately 4 feet in width with dark brown stains on the foor tile extending 4 to 6 inches in front of the cabinet. Observation on 03/19/15 at 1.45 pm of the Maintenance Contract worker painting the walls in Room #103. Interview on 3/19/15 at 1.45 pm with a resident of Room #103 revealed: -The ceiling tiles and the light fixture covers had been stained "for awhile", but he did not know how long. -The bottom of the sink cabinet and the floor in front of the sink was stained due to the sink overflowing with water. -The water had been turned off to both sinks since the previous week due to plumbing issuesStaff had contacted a plumber who was to be coming soon to fix the sink. -The resident used a sink in a common bathroom when needed.	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	COMPLE	IED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 074 Continued From page 10 -A double sink with a cabinet measuring approximately 5 feet in width with dark brown stains on the bottom wooden baseboard with the stains extending the length of the cabinet measuring approximately 4 feet in width with dark brown stains on the foor tile extending 4 to 6 inches in front of the cabinet. Observation on 03/19/15 at 1.45 pm of the Maintenance Contract worker painting the walls in Room #103. Interview on 3/19/15 at 1.45 pm with a resident of Room #103 revealed: -The ceiling tiles and the light fixture covers had been stained "for awhile", but he did not know how long, -The bottom of the sink cabinet and the floor in front of the sink was stained due to the sink overflowing with water. -The water had been turned off to both sinks since the previous week due to plumbing issuesStaff had contacted a plumber who was to be coming soon to fix the sinkThe resident used a sink in a common bathroom when needed.							
CHINA GROVE RETIREMENT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 074 Continued From page 10 -A double sink with a cabinet measuring approximately 5 feet in width with dark brown stains on the bottom wooden baseboard with the stains extending the length of the cabinet measuring approximately 4 feet in width with dark brown stains on the Bottot tie cabinet. -Tile flooring in front of the double sink cabinet measuring approximately 4 feet in width with dark brown stains on the Boot tile extending 4 to 6 inches in front of the cabinet. Observation on 03/19/15 at 1:45 pm of the Maintenance Contract worker painting the walls in Room #103. Interview on 3/19/15 at 1:45 pm with a resident of Room #103 revealed: -The ceiling tiles and the light fixture covers had been stained "for awhile", but he did not know how long. -The bottom of the sink cabinet and the floor in front of the sink cabinet and the floor in floor in floor in floor in floor in floor in flo			HAL080020	B. WING		03/20)/2015
CHINA GROVE RETIREMENT CENTER (X4) ID (X4) ID (EACH DETICIENCY MUST BE PRECEDED BY FULL (EACH DETICIENCY MUST BE PRECEDED BY FULL (EACH DETICIENCY MUST BE PRECEDED BY FULL TAG MEDIATIVE	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHINA GROVE, NC 28023 CALLANDER CALLA			1114 SOUT	H MAIN STRE	ET		
PREFIX TAG	CHINA GE	OVE RETIREMENT CEN	CHINA GR	OVE, NC 2802	3		
-A double sink with a cabinet measuring approximately 5 feet in width with dark brown stains on the bottom wooden baseboard with the stains extending the length of the cabinet. -Tile flooring in front of the double sink cabinet measuring approximately 4 feet in width with dark brown stains on the floor tile extending 4 to 6 inches in front of the cabinet. Observation on 03/19/15 at 1:45 pm of the Maintenance Contract worker painting the walls in Room #103. Interview on 3/19/15 at 1:45 pm with a resident of Room #103 revealed: -The ceiling tiles and the light fixture covers had been stained "for awhile", but he did not know how longThe bottom of the sink cabinet and the floor in front of the sink was stained due to the sink overflowing with waterThe water had been turned off to both sinks since the previous week due to plumbing issuesStaff had contacted a plumber who was to be coming soon to fix the sinkThe resident used a sink in a common bathroom when needed.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
approximately 5 feet in width with dark brown stains on the bottom wooden baseboard with the stains extending the length of the cabinet. -Tile flooring in front of the double sink cabinet measuring approximately 4 feet in width with dark brown stains on the floor tile extending 4 to 6 inches in front of the cabinet. Observation on 03/19/15 at 1:45 pm of the Maintenance Contract worker painting the walls in Room #103. Interview on 3/19/15 at 1:45 pm with a resident of Room #103 revealed: -The ceiling tiles and the light fixture covers had been stained "for awhile", but he did not know how long. -The bottom of the sink cabinet and the floor in front of the sink was stained due to the sink overflowing with water. -The water had been turned off to both sinks since the previous week due to plumbing issues. -Staff had contacted a plumber who was to be coming soon to fix the sink. -The resident used a sink in a common bathroom when needed.	D 074	74 Continued From page 10		D 074			
with several cleaning agents, but could not remove the stains. Interview on 3/18/15 at 9:22 am with another resident of Room #103 revealed: -There were plumbing problems with the toilet and the sink in their room and the water had been turned off to both the toilet and the sink since last weekStaff had contacted a plumber who was to be	D 074	-A double sink with a approximately 5 feet is stains on the bottom is stains extending the lateral flooring in front of measuring approximately brown stains on the flooring in front of the compartment of the singular flooring tiles and been stained "for awhow long. -The ceiling tiles and been stained "for awhow long. -The bottom of the singular front of the sink was soverflowing with wate. -The water had been since the previous we staff had contacted a coming soon to fix the staff had contacted a coming soon to fix the staff had tried to clean with several cleaning remove the stains. Interview on 3/18/15 are sident of Room #10. -There were plumbing and the sink in their returned off to both the week.	cabinet measuring in width with dark brown wooden baseboard with the ength of the cabinet. In the double sink cabinet ately 4 feet in width with dark oor tile extending 4 to 6 cabinet. If the double sink cabinet ately 4 feet in width with dark oor tile extending 4 to 6 cabinet. If the double sink cabinet at 1:45 pm of the ext worker painting the walls in the light fixture covers had nile", but he did not know the cabinet and the floor in stained due to the sink ext. The turned off to both sinks each due to plumbing issues. It is a plumber who was to be the sink. It is sink in a common bathroom and the cabinet and the floor agents, but could not the sink ext. The cabinet and the floor agents, but could not the water had been toilet and the sink since last.	D 074			

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 11 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		HAL080020	B. WING		03/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE. ZIP CODE		
			TH MAIN STRE	,		
CHINA GR	OVE RETIREMENT CEN	TER	OVE, NC 2802			
			T 2002			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 074	Continued From page	e 11	D 074			
	on 10/19/15 at 10:30 -She was previously or returned in September-She was aware that stains on the ceiling to the sink cabinet and fished area of resident resident resident resident resident was not sure of the ceiling tiles and light area of the broom the sink cabinet was from #103 had previous coffee" in his roomThe resident would pand run water over it staff had talked with longer made "sock corshe and a Personal the bottom of the sink front of the sink with scould not remove the	employed at the facility and er 2014 as the RCD. there were multiple brown files, light covers, bottom of floor in front of the double from #103. The cause for the stains on 19th covers. It is a resident residing in 19th pour tour making "sock for make coffee in a sock to make coffee. The resident and he no 19th pour tour in his room. Care Aide had tried to clean a cabinet and the floor in 19th pour tour tour the resident and the floor in 19th pour tour the resident and the floor in 19th pour the resident and 19th pou				
	hallways and in some	evealed: aced some ceiling tiles in the of the residents' rooms. which rooms he had replaced				
	the ceiling tilesHe was in the proces -His company came t	es of painting every room. o see what needed to be n ordered the materials and				
D 088	10A NCAC 13F .0306 Furnishings	(b)(2) Housekeeping And	D 088			
	10A NCAC 13F .0306	6 Housekeeping And				

Division of Health Service Regulation

STATE FORM 8899 XBF311 If continuation sheet 12 of 37

MALOBRO2D MARE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE THING ARROVE RETIREMENT CENTER CHINA GROVE RETIREMENT CENTER SUPPLIES SUPP	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CHINA GROVE RETIREMENT CENTER 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 PROVIDERS ALL OF CORRECTION (EACH DEFINISHING WITH THE PRECIDENCES THE PRETTY TAG CORRECTION PRINT) (EACH DEFINISHING WITH THE PRECIDENCES THE PRETTY TAG CORRECTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DATE (TO NOT TAG TAGE OF THE APPROPRIATE DATE (TO NOT TAG TAGE OF THE APPROPRIATE DATE (TO NOT TAGE OF TAGE OF THE APPROPRIATE DATE (TO NOT TAGE OF TAGE OF THE APPROPRIATE DATE (TO NOT TAGE OF TAGE OF THE APPROPRIATE DATE (TO NOT TAGE OF THE APPROPRIATE DATE (TO NOT TAGE OF THE APPROPRIATE DATE (TO NOT TAGE OF THE APPR			HAL080020	B. WING		03/20/20	015
CHINA GROVE RETIREMENT CENTER (X4) ID SUMMARY STAIREMENT OF DEFICIENCIES PREFIX TAG SEMMARY STAIREMENT OF DEFICIENCY PREFIX TAG CROSS-AFFERNATION ON USE OF PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D 088 Continued From page 12 (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (2) a bedside type table; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide bedside tables for 4 of 10 resident's rooms (Rooms #102, #103, #107, and #108) and failed to maintain bedside tables in good repair for 1 of 10 residents' rooms (Room #103) as required. The findings are: A. Observations during facility tour on 03/18/15 from 8:45 am to 9:45 am of Hall A (Rooms #101, #102, #103, #104) revealed: -Room #101 had 3 residents and 3 bedside tablesRoom #101 had 3 residents and 2 bedside tablesRoom #103 had 4 residents and 4 bedside tablesBoth bedside tables in Room #103 had handles missingRoom #104 had 4 residents and 4 bedside tables. Interview on 03/19/15 at 11:30 am with a resident who resided in Room #102 revealed he had sufficient storage and did not feel he needed a bedside table.	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 088 Continued From page 12 (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (2) a bedside type table; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide bedside tables for 4 of 10 resident's rooms (Room #103) as required. The findings are: A. Observations during facility tour on 03/18/15 from 8.45 am to 9.45 am of Hall A (Rooms #101, #102, #103, #104) revailed: -Room #101 had 3 residents and 3 bedside tablesRoom #103 had 4 residents and two bedside tablesRoom #103 had 4 residents and 4 bedside tablesRoom #104 had 4 residents and 4 bedside tablesRoom #105 had 6 residents and 4 bedside tablesRoom #104 had 7 residents and 4 bedside tablesRoom #105 had 6 residents and 4 bedside tablesRoom #106 had 7 residents and 4 bedside tablesRoom #107 had 7 residents and 4 bedside tablesRoom #108 had 6 residents and 8 bedside tablesRoom #108 had 7 residents and 8 bedside tablesRoom #108 had 7 residents and 8 bedside tablesRoom #108 had 8 residents and 8 bedside tablesRoom #109 had 9 residents and 8 bedside tablesRoom #108 had 9 residents and 8 bedside tablesRoom #109 had 9 residents and 9 bedside tablesRoom #108 had 9 residents and 9 bedside tablesRoom #109 had 9 residents and 9 bedside tables had sufficient storage and did not feel he needed a bedside table.	CHINA GF	ROVE RETIREMENT CEN	TER				
(b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (2) a bedside type table; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide bedside tables for 4 of 10 resident's rooms (Rooms #102, #103, #107, and #108) and failed to maintain bedside tables in good repair for 1 of 10 residents' rooms (Room #103) as required. The findings are: A. Observations during facility tour on 03/18/15 from 8:45 am to 9:45 am of Hall A (Rooms #101, #102, #103, #104) revealed: -Room #101 had 3 residents and 3 bedside tablesRoom #102 had 3 residents and 2 bedside tablesRoom #103 had 4 residents and two bedside tablesRoom #104 had 4 residents and two bedside tablesRoom #104 had 4 residents and 4 bedside tablesRoom #104 had 4 residents and 4 bedside tablesRoom #105 had 4 residents and 4 bedside tablesRoom #106 had 4 residents and 4 bedside tablesRoom #107 had 5 residents and 4 bedside tablesRoom #108 had 4 residents and 4 bedside tablesRoom #108 had 4 residents and 4 bedside tablesRoom #108 had 6 residents and 8 bedside tablesRoom #108 had 6 residents and 8 bedside tablesRoom #108 had 6 residents and 8 bedside tablesRoom #108 had 7 residents and 8 bedside tablesRoom #108 had 6 residents and 9 bedside tablesRoom #108 had 7 residents and 9 bedside tables.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE C	OMPLETE
who resided in Room #103 revealed: -He was not sure how long the handles had been	D 088	(b) Each bedroom sh furnishings in good re resident: (2) a bedside type tab. This Rule shall apply facilities. This Rule is not met Based on observation failed to provide beds resident's rooms (Rood #108) and failed to m good repair for 1 of 10 #103) as required. The findings are: A. Observations durin from 8:45 am to 9:45 #102, #103, #104) rev-Room #101 had 3 retablesRoom #102 had 3 retablesRoom #103 had 4 retablesBoth bedside tables missingRoom #104 had 4 retables. Interview on 03/19/15 who resided in Room sufficient storage and bedside table. Interview on 03/19/15 who resided in Room sufficient storage and bedside table.	pair and clean for each oble; to new and existing as evidenced by: as and interviews, the facility ide tables for 4 of 10 oms #102, #103, #107, and aintain bedside tables in 0 residents' rooms (Room of Hall A (Rooms #101, vealed: sidents and 3 bedside sidents and 2 bedside sidents and 2 bedside sidents and 4 bedside in Room #103 had handles sidents and 4 bedside of at 11:30 am with a resident #102 revealed he had did not feel he needed a sident are sident #103 revealed:	D 088			

Division of Health Service Regulation

STATE FORM STATE FORM XBF311 If continuation sheet 13 of 37

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL080020	B. WING		03/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHINA GF	ROVE RETIREMENT CEN	TER	H MAIN STRE OVE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 088	Continued From page	2 13	D 088			
	tableHe had not reported	the drawer to the bedside to anyone that the handles				
	were missing on his b	pedside table.				
	Refer to interview with (RCD) on 03/19/15 at	n the Resident Care Director 5:30 pm.				
	Refer to interview witl 03/19/15 at 12:50 pm	n Corporate Administrator on .				
	from 8:45 am to 9:45 105,106,107,108,109 -Room # 107 had 2 re tables.	•				
	revealed: -He had resided in the -He had never had a -He had never reques administration.	ent on 3/19/15 at 11:20 am e facility for 6 months. bedside table in his room. sted a bedside table to side table if he had one.				
	Refer to interview witl (RCD) on 03/19/15 at	n the Resident Care Director 5:30 pm.				
	Refer to interview with 03/19/15 at 12:50 pm	n Corporate Administrator on				
	revealed she had rec	at 5:30 pm with the RCD eived no requests from bedside tables or for the table.				
	Interview with the Cor	rporate Administrator on				

Division of Health Service Regulation

STATE FORM STATE FORM SHEET 14 of 37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		03	/20/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
CHINA GF	OVE RETIREMENT CEN	TER	JTH MAIN STREE ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 088	dressers over the pase. She was not aware to be be be tablesShe had not received residents for a bedside	revealed: hased bedside tables and st two years. hat 6 residents did not have d any requests from le table. hat there were handles	D 088			
D 090	Furnishings 10A NCAC 13F .0306 Furnishings (b) Each bedroom sh furnishings in good reresident: (4) a wall or dresser each resident; This Rule shall apply facilities. This Rule is not met Based on observation failed to furnish a wal 10 residents' rooms thresident (Rooms #102 #109, and #110). A. Observations durin from 8:45 am to 9:45 #102, #103, #104) remirror and three resident three residents with 3 residen	pall have the following spair and clean for each mirror that can be used by to new and existing as evidenced by: an and interview, the facility or dresser mirror in 7 out of nat could be used by each 2, #105, #106, #107, #108, ag facility tour on 03/18/15 am of Hall A (Rooms #101, wealed Room #102 had no lents. dents who resided in Room 8:30 pm revealed: as that were on the wall in	D 090			

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 15 of 37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		HAL 090020	B. WING			10010045
		HAL080020			03	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CHINA GF	ROVE RETIREMENT CEN	TER	UTH MAIN STREE			
		CHINA G	ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 090	Continued From page	e 15	D 090			
	mirror at a local thrift	the bedroom. nsidered purchasing a				
	there were floor to ce	1/15 at 3:50 pm revealed iling mirrors on one wall in ed across from Room #102.				
	Refer to interview with 03/19/15 at 2:30 pm.	n a Personal Care Aide on				
	Refer to interview with on 03/19/15 at 5:30 p	n the Resident Care Director m.				
	Refer to interview with Administrator on 03/2					
	from 8:45 am to 9:45 #106, #107, #108, #1 -Room #105 had thre -Room #106 had two -Room #107 had two -Room #108 had two -Room #109 had thre	g facility tour on 3/18/15 am of Hall B (Rooms #105, 09, and #110) revealed: e residents and no mirrors. residents and no mirrors. residents and no mirrors. residents and no mirrors. e residents and no mirrors. residents and no mirrors.				
	mentioned above on a -He had never had a -He had to go to the s ready.	shared bathroom to get e a mirror in his room.				
	Interview with a reside	ent from one of the rooms				

Division of Health Service Regulation

STATE FORM STATE FORM SHEET 16 of 37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
	HAL080020	B. WING		03	/20/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
CHINA GROVE RETIREMENT CENT	rer - Ter	TH MAIN STRE ROVE, NC 2802				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
-He had never had a needs a mirrorHe had never request administration. Refer to interview with (PCA) on 03/19/15 at 3. Refer to interview with on 03/19/15 at 5:30 processor of the processo	a/19/15 at 2:15 pm revealed: nirror in his room. com across the hall if he ted a mirror to a Personal Care Aide 3:30 pm. the Resident Care Director m. the Corporate 0/15 at 3:00 pm. on 3/19/15 at 2:30 pm cloyment, did not recall the rooms. esidents had not having mirrors in their at 5:30 pm with the or revealed she had from residents for mirrors in	D 090				

Division of Health Service Regulation

STATE FORM 8899 XBF311 If continuation sheet 17 of 37

PRINTED: 04/06/2015 FORM APPROVED

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		.servinos in ordination	A. BUILDING: _		
		HAL080020	B. WING		03/20/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		1114 SOU	TH MAIN STRE	ET	
CHINA GR	OVE RETIREMENT CEN	TER CHINA GF	ROVE, NC 2802	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 091	Continued From page	e 17	D 091		
D 091	10A NCAC 13F .0306 Furnishings	S(b)(5)(6) Housekeeping And	D 091		
	resident: (5) a minimum of one or straight, arm or wit resident), high enoug (6) additional chairs a by visitors; This Rule shall apply facilities. This Rule is not met Based on observation failed to provide a min chair for each resident	pall have the following epair and clean for each comfortable chair (rocker hout arms, as preferred by h from floor for easy rising; evailable, as needed, for use to new and existing as evidenced by: as and interviews, the facility nimum of one comfortable at in 10 of 10 resident 101, #102, #103, #104,			
	The findings are:				
	from 8:45 am to 9:45 #102, #103, and #104 -Room #101 had thre -Room #102 had thre -Room #103 had four -Room #104 had four -The dining room loca the hall from rooms # had 24 chairs utilized	ing facility tour on 03/18/15 am of Hall A (Rooms #101, 4) revealed: e residents and no chairs. e residents and no chairs. residents and no chairs. residents and no chairs. ated on the opposite side of 101, #102, #103, and #104 for meals for residents.			
		ere were enough chairs in			

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 18 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		HAL080020	B. WING		03	3/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
CLUNA OF	OVE DETIDEMENT OF	1114 SOL	JTH MAIN STREET	Ī		
CHINA GI	ROVE RETIREMENT CEN	CHINA G	ROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 091	Continued From page	e 18	D 091			
	the dining room to se	rve the residents that came				
	to the dining room for					
	Interviews with 5 resign	dents who resided in Rooms				
		id #104 on 03/19/15 from				
	1:30 pm to 1:50 pm re					
		unaware that the facility was				
	supposed to provide	each resident with a				
	comfortable chair.	nterviewed did not want a				
	chair in their room.	nerviewed did flot want d				
	-One of 4 residents in	nterviewed wanted a chair in				
	their bedroom.					
		hat they would sit in the				
	1 -	a chair from the dining room				
	area when they had v	VISILOIS.				
	Refer to interview wit (PCA) on 03/19/15 at	h a Personal Care Aide : 2:30 pm.				
	Refer to interview wit (RCD) on 03/19/15 at	h the Resident Care Director t 5:30 pm.				
	Refer to interview wit 03/20/15 at 3:00 pm.	h the Administrator on				
	· -	g facility tour on 3/18/15				
		am of Hall B (Rooms #105,				
		09, and #110) revealed:				
		e residents and no chairs.				
		residents and no chairs.				
		residents and no chairs.				
		e residents and no chairs.				
	-Room #110 had two	residents and no chairs.				
	Interview with a resid	ent from one of the above				
	mentioned rooms on					
	revealed:	·				
	-He had never had a					
	-He would like to have	e a chair in his room for				

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 19 of 37

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		03	20/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA				
CHINA GF	ROVE RETIREMENT CEN	TER	JTH MAIN STREI ROVE, NC 2802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
D 091	Continued From page	e 19	D 091				
	visitorsHe had never requested a chair for his room to administration.						
	Interview with a resid- mentioned rooms on revealed:	ent from one of the above 3/19/15 at 11:25 am					
	-He had never had a chair in his room"It would be nice to have one for my mom when she visits."						
	Interview with a resident from one of the above mentioned rooms on 3/19/15 at 2:15 pm revealed:						
	-He had never had a -"I could use a chair if -He had never reques administration.						
		ver area when visitors came					
	Refer to interview witl (PCA) on 03/19/15 at	h a Personal Care Aide 2:30 pm.					
	Refer to interview with the Resident Care Director (RCD) on 03/19/15 at 5:30 pm.						
	Refer to interview with Administrator on 03/2	•					
	revealed: -Since she began em chairs ever being in the						
	rooms.	t having chairs in their they sat on the residents'					

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 20 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL080020	B. WING		03/20/2015
NAME OF D			DECC CITY CTA	TE 710 000E	1 03/20/2013
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA TH MAIN STRE		
CHINA GROVE RETIREMENT CENTER			OVE, NC 2802		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 091	1 Continued From page 20		D 091		
	revealed: -She was previously of returned in September -She had received not a chair in their room. Interview with the Cot 03/20/15 at 3:00 pm results -She was unaware the provided for each results -She had not received chairs in their roomsThe facility had not performed in their rooms.	requests from residents for reporate Administrator on revealed: at a chair was to be ident. d requests from residents for purchased any chairs for e she had been Corporate			
D 093	Furnishings 10A NCAC 13F .0306 Furnishings (b) Each bedroom sh furnishings in good re resident: (8) a light overhead or reach of person lying	nall have the following epair and clean for each of bed with a switch within on bed; or a lamp. The light um of 30 foot-candle power ding.	D 093		
	failed to assure there bed with a switch with	as evidenced by: ns and interviews, the facility was a light overhead of the nin reach of residents lying in p for 10 of 10 residents'			

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 21 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL080020	B. WING		03/2	0/2015
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/2	
CHINA GR	OVE RETIREMENT CEN	TER	H MAIN STRE OVE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 093	Continued From page	21	D 093			
	#101, #102, #103, #1 #109, and #110).	04, #105, #106, #107, #108,				
	The findings are:					
	8:45 am to 9:45 am o #103, #104) revealed -An on/off switch loca entrance door of each multiple overhead fluct -None of the overhead independentlyThe on/off switch couresidents while lying i -Room #101 had three (accessible to the res lamp did not workRoom #102 had three lamp (the lamp was a and was accessible a -Room #103 had four lampsRoom #104 had four	ted next to the left of the n room that operated prescent lights in each room. It is in the lights were operable and not be accessed by the n bed. The residents and 1 ident) bedside lamp, but the le residents and 1 bedside pproximately 8 inches tall				
	who resided in room #	e a lamp at his bedside.				
	who resided in Room -He would like to have -He had considered b a local thrift store.	at 11:30 am with a resident #102 revealed: e a lamp at his bedside. buying a lamp for his room at d a lamp for his room from				

Division of Health Service Regulation

STATE FORM STATE FORM XBF311 If continuation sheet 22 of 37

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMF	SURVEY
		A. BUILDING: _	A. BUILDING:		
	HAL080020	B. WING		03.	/20/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHINA GROVE RETIREMENT CENTE	R	TH MAIN STRE			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
who resided in Room #7 -She only had a small lashe had bought herselfShe liked to read and wif it was providedThere were four people and sometimes she did lights because it disturb. Interview on 03/19/15 at who resided in Room #7 -He had a lamp "but I nethis one doesn't work." -Resident demonstrated workHe had not reported to work. Interview on 03/19/15 at who resided in Room #7 -There were no lamps in -There were 4 residents -He enjoyed reading at because turning the over his roommatesHe had not requested at Refer to interview with a (PCA) on 03/19/15 at 2: Refer to interview with the (RCD) on 03/19/15 at 5: Refer to interview with the Administrator on 03/20/18 B. Observation during for the same and the sa	t 1:30 pm with a resident 104 revealed: amp that was 8 inches tall vould like a bedside lamp e residing in one room, not turn on the overhead ed her roommates. t 1:40 pm with a resident 101 revealed: eed another one because d that the light did not staff that the lamp did not t 1:45 pm with a resident 103 revealed: n his room. s residing in Room #103. night, but could not erhead light on disturbed a lamp from staff. a Personal Care Aide 30 pm. the Resident Care Director 30 pm. the Corporate 15 at 3:00 pm. facility tour on 3/18/15 m of Hall B (Rooms #105,	D 093			

Division of Health Service Regulation

STATE FORM STATE FORM SHEET 23 of 37

ווטופועום	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL080020	B. WING		03/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	
TVAINE OF T	KOVIDER OR OUT FEER		TH MAIN STRE		
CHINA GROVE RETIREMENT CENTER			ROVE, NC 2802		
	OUR MAR DV OT				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
D 093	Continued From page	23	D 093		
	-Room #105 had thre	e residents and no bedside			
	lamps.				
		residents and no bedside			
	lamps.				
		residents and no bedside			
	lamps.	residents and one bedside			
	lamp.	residents and one bedside			
	•	e residents and no bedside			
	lamp.				
	-Room #110 had two	residents and one bedside			
	lamp.				
	_	light with the on/off switch			
		to the entrance door of each			
	room.	uld not be accessed by the			
	residents while lying i				
		ent from one of the above			
	mentioned rooms on revealed:	3/19/15 at 11.20 am			
	-He had never had a	bedside lamp.			
	-His room mate has a	•			
	-He does not need on	ne because of the lighting			
	from the windows.				
	-He had never reques	sted a lamp to			
	administration.				
	Refer to interview with	h a Personal Care Aide			
	(PCA) on 03/19/15 at				
	,	•			
		h the Resident Care Director			
	(RCD) on 03/19/15 at	5:30 pm.			
	Defer to intensions :::	h the Cornerate			
	Refer to interview with				
	Administrator on 03/2	ω το αι ο.υυ μπ.			
	Interview with a PCA	on 3/19/15 at 2:30 pm			

Division of Health Service Regulation

revealed:

STATE FORM 8899 XBF311 If continuation sheet 24 of 37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		HAL080020	B. WING		03	/20/2015
	ROVIDER OR SUPPLIER	1114 SO	DDRESS, CITY, STATE UTH MAIN STREET BROVE, NC 28023			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 093	bedside lamps in every -As far as she knew, complained about not their rooms. Interview on 03/19/15 revealed: -She was previously returned in September-She had received not bedside lamps. Interview on 03/20/15 Corporate Administration-She was unaware the provided for each resumps in their roomsThe facility had not presume the service of the ser	ployment, did not recall ry room. residents had not thaving bedside lamps in at 5:30 pm with the RCD employed at the facility and er 2014 as the RCD. To requests from residents for at 3:00 pm with the tor revealed: That is a bedside lamp was to be ident. To requests from residents for the purchased any lamps for e she had been Corporate	D 093			
D 105	10A NCAC 13F .0311 (a) The building and mechanical, and plun care home shall be moperating condition. This Rule is not met Based on observation failed to assure the owere working proper! (Halls A and B, dining residents' rooms (Roo	(a) Other Requirements Other Requirements all fire safety, electrical, his properties and an adult haintained in a safe and as evidenced by: as and interviews, the facility everhead fluorescent lights by throughout the facility. If area, and 10 out of 10 pms #101, #102, #103, and #109, and #110)	D 105			

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 25 of 37

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		03/20/2015	
NAME OF D			DDEGG OITY OTA	TF 7/D 00DF	1 03/20/2013	'
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA TH MAIN STRE			
CHINA GR	OVE RETIREMENT CEN	TER	ROVE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMP	LETE
D 105	Continued From page	25	D 105			
	The findings are: Observation during the throughout the day or - The facility had 27 fl (each constructed to the ceilings tiles of the entrance foyer/sitting - Twenty-six of the 27 ceiling were not work bulbs in the hallways area, and entrance for Residents' rooms had overhead fluorescent properly or missing but A. Observation on 3/fluorescent light fixture revealed two rows of feet apart beginning of foyer wall, and a 4 but alcove within the dining and a television) with - One row had one fix one fixture had all 4 but had 2 of 4 bulbs burning The other row had 5 bulbs burning. Refer to interview with (RCD) on 3/19/15 at 6	the initial tour on 3/18/15 and an 3/19/15 revealed: Ituorescent light fixtures contain 4 bulbs) recessed in the hallways, dining area, and area. If fluorescent lights in the ing properly or were missing (Hall A and Hall B), dining hyer/sitting area. If of the 4 bulb light fixtures not working bulbs. 18/15 of the 4 bulb less in dining hall area in dining hall area in fixtures spaced about 4 in fixtures for the entrance of the fixture located in an ing room (containing 2 chairs lighting as follows: Iture with no bulbs burning, bulbs burning and 3 fixtures ing. If of 5 fixtures with 2 of 4 in the entrance of the fixture with no bulbs burning. If of 5 fixtures with 2 of 4 in the entrance of the fixtures with 2 of 4 in the entrance of the fixtures with 2 of 4 in the entrance of the fixtures with 2 of 4 in the entrance of the fixtures with 2 of 4 in the entrance of the fixtures with 2 of 4 in the entrance of the				
	Refer to Interview with	h Corporate Administrator				

Division of Health Service Regulation

on 3/19/15 at 2:40 pm.

STATE FORM 8899 XBF311 If continuation sheet 26 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL080020	B. WING		03	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHINA GF	ROVE RETIREMENT CEN	TER	TH MAIN STRE ROVE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 105	Continued From page	26	D 105			
	am of the the 4 bulb f ceiling on the east en - The light fixture was chair and table with the telephone located on - The fixture only had - The light bulbs in the flickering.	located directly above a ne residents' facility the table. 2 of 4 bulbs. e fixture were constantly				
	The resident had resayear.The flickering light in (above the telephone almost a year.	with a resident revealed: sided at the facility for about the fixture at the end of hall had been flicking for the resident a headache. s they would fix it."				
	in Room #109 (last ro light over the telephor - The light fixture "doe the lights were on. - The flickering bother door was shut. - Staff sometimes turn - The bulbs had been	red them at night unless the ned the light off at night. flickering for at least a year. bld administration about the				
	Refer to interview with am.	n RCD on 3/19/15 at 10:57				
	Refer to interview witl on 3/19/15 at 11:00 a	n Maintenance Contractor m.				
	Refer to Interview with on 3/19/15 at 2:40 pm	h Corporate Administrator า.				

Division of Health Service Regulation

STATE FORM STATE FORM XBF311 If continuation sheet 27 of 37

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		HAL080020	B. WING		03/2	0/2015
NAME OF PR	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHINA CD	OVE RETIREMENT CEN	TER 1114 SOUT	H MAIN STRE	ET		
CHINA GR	OVE RETIREMENT CEN	CHINA GRO	OVE, NC 2802	3		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 105	Continued From page	27	D 105			
	from 8:45 am to 9:45 #106, #107, #108, #1 -Room #105 had 2 of working properlyRoom #106 had 2 of working properlyRoom #107 had 4 of working properly, one crackedRoom #108 had 2 of working properlyRoom #109 had 2 of working properlyRoom #100 had 2 of working properlyRoom #110 had 2 of working properly, with missing (the bulbs dic prevent shattering)Hall B had 6 of 6 ceil properlyHall B had 1 of the 6 the cover (the bulbs of to prevent shattering) Interview with a reside mentioned rooms on revealed: -The overhead lights while now"He had never reported Interview with a reside mentioned rooms on revealed: -He had never paid at fixtures.	ent from one of the above 3/19/15 at 11:20 am had been that way for "a ed it to the Administrator.				

Division of Health Service Regulation

Refer to interview with RCD on 3/19/15 at 10:57

STATE FORM STATE FORM SHEET 28 of 37

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
744012744	or contraction	ibertii io, tiiot itombetti	A. BUILDING: _		O O IVIII E	
		HAL080020	B. WING		03/2	0/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHINA CE	OVE DETIDEMENT CEN	TER 1114 SOUT	H MAIN STRE	ET		
CHINA GR	ROVE RETIREMENT CEN	CHINA GR	OVE, NC 2802	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 105	Continued From page	28	D 105			
	am.					
	u					
	Refer to interview with on 3/19/15 at 11:00 a	n Maintenance Contractor m.				
	Refer to Interview with on 3/19/15 at 2:40 pm	h Corporate Administrator า.				
	from 8:45 to 9:45 am #101, #102, #103, an -Room #101 had 4 flu constructed to contain ceiling for a total of 16 -Fifteen of the 16 fluo were not working propin Room #101. -Three residents residence -Room #102 had 4 fluconstructed to contain ceiling for a total of 16 -Eight of the 16 fluore	torescent light fixtures (each of 4 bulbs) recessed in the solight bulb positions. The rescent lights in the ceiling perly or were missing bulbs and all the received bulbs. The rescent light fixtures (each of 4 bulbs) recessed in the solight bulb positions. The rescent lights in the ceiling are second bulbs in the ceiling.				
	in Room #102. -Room #102 had 2 of missing the cover (the sleeve to prevent shatanger) -Three residents residents residents residents residents residents residents residents receiling for a total of 24	ded in Room #102. lorescent light fixtures (each n bulbs) recessed in the				
	were not working propin Room #103Directly overhead at light fixture which was bulb without a cover c-Four residents resided -Room #104 had 7 flu	the entry door was a single son with a single halogen on the fixture.				

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 29 of 37

D 105 Continued From page 29 ceiling for a total of 28 light bulb positionsSixteen of the 28 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #104Room #104 had 2 of 7 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering)Four residents resided in Room #104.		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER CHINA GROVE RETIREMENT CENTER 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 105 Continued From page 29 ceiling for a total of 28 light bulb positionsSixteen of the 28 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #104Room #104 had 2 of 7 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering)Four residents resided in Room #104.				A. BOILDING			
CHINA GROVE RETIREMENT CENTER CHINA GROVE, NC 28023 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 105 Continued From page 29 ceiling for a total of 28 light bulb positionsSixteen of the 28 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #104Room #104 had 2 of 7 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering)Four residents resided in Room #104.			HAL080020	B. WING		03/2	20/2015
CHINA GROVE RETIREMENT CENTER CHINA GROVE, NC 28023 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 105 D 105 D 105 Continued From page 29 Ceiling for a total of 28 light bulb positionsSixteen of the 28 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #104Room #104 had 2 of 7 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering)Four residents resided in Room #104.	NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 105 Continued From page 29 ceiling for a total of 28 light bulb positionsSixteen of the 28 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #104Room #104 had 2 of 7 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering)Four residents resided in Room #104.	CHINA GI	ROVE RETIREMENT CEN	ITER				
ceiling for a total of 28 light bulb positionsSixteen of the 28 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #104Room #104 had 2 of 7 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering)Four residents resided in Room #104.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
#103 on 3/19/15 at 11:30 am revealed: He would like to have more light in his room for reading. -Some of the overhead lights had been missing bulbs or were burned out for "a long time." -He had not requested that staff repair the overhead lights. Interview with a resident who resided in Room #104 on 3/19/15 at 1:30 pm revealed: -Her room was missing several overhead lights, but this did not bother her. -She had not requested that staff repair the overhead lights. Interview with a resident who resided in Room #101 on 3/19/15 at 11:45 am revealed: -He had been a resident at the facility for two months. -The light fixtures had been missing bulbs since he has been at the facility. -He would like to have more light in his room. -He had not requested that staff repair the overhead lights. Refer to interview with RCD on 3/19/15 at 10:57 am. Refer to interview with Maintenance Contractor on 3/19/15 at 11:00 am.	D 105	ceiling for a total of 28 -Sixteen of the 28 flux were not working profin Room #104Room #104 had 2 of missing the cover (the sleeve to prevent sha -Four residents reside Interview with a resid #103 on 3/19/15 at 13 -He would like to have readingSome of the overhead bulbs or were burned -He had not requeste overhead lights. Interview with a resid #104 on 3/19/15 at 13 -Her room was missir but this did not bother -She had not request overhead lights. Interview with a resid #101 on 3/19/15 at 13 -He had been a resid monthsThe light fixtures had he has been at the fa -He would like to have -He had not requeste overhead lights. Refer to interview with am. Refer to interview with	B light bulb positions. Drescent lights in the ceiling perly or were missing bulbs 7 fluorescent light fixtures e bulbs did have a protective litering). Ded in Room #104. Ent who resided in Room for an	D 105			

Division of Health Service Regulation

STATE FORM 8899 XBF311 If continuation sheet 30 of 37

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE	SURVEY
ANDILAN	SI CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COM	LLILD
		HAL080020	B. WING		03	20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHINA GE	ROVE RETIREMENT CEN	ITER 1114 SOU	TH MAIN STREI	ET		
		CHINA GF	ROVE, NC 2802	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 105	Continued From page	e 30	D 105			
	Refer to Interview wit on 3/19/15 at 2:40 pn	h Corporate Administrator n.				
	3/19/15 at 10:57 am in She was previously or returned in September The process for repainformed the Corporal informed the Mainten She was aware of the needed. She had reported it to Administrator in September around that tin Interview with the Ma 3/19/15 at 11:00 am in the He had already replains. He was in the process the was in the process.	employed at the facility and er 2014 as the RCD. airs was that the RCD te Administrator whom then ance Supervisor. e ceiling light fixtures repairs to the Corporate ember 2014 and repairs ne. intenance Contractor on revealed: aced 10-12 ceiling light red other materials for the ses of painting every room. to see what needed to be an ordered the materials and				
	Interview with Corpor at 2:40 pm revealed: -She was aware there not working properly: -She had reported it t Supervisor but did incidence of the stated that the staff had installed probulbs in fixtures without shattering of the bulb-She stated that most	ate Administrator on 3/19/15 e were ceiling light fixtures and missing covers. to the Maintenance dicate when. subcontracted maintenance tective coverings for the but covers to prevent				

Division of Health Service Regulation

STATE FORM STATE FORM SHEET STATE STATE FORM STATE FOR STATE FORM STATE FOR STATE F

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL080020	B. WING		03	/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CHINA GF	ROVE RETIREMENT CEN	TER	JTH MAIN STRE ROVE, NC 2802			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 105	Continued From page	e 31	D 105			
	replacements. (No into or when ordered was	formation for parts ordered available for review.)				
D 137	10A NCAC 13F .0407 Qualifications	7(a)(5) Other Staff	D 137			
	(a) Each staff person shall:(5) have no substant	7 Other Staff Qualifications at an adult care home iated findings listed on the a Care Personnel Registry IE-256;				
	facility failed to ensur B) had no substantial Carolina Health Care prior to hire according	and record reviews, the e 1 of 3 sampled staff (Staff findings listed on the North Personnel Registry (HCPR)				
	-	sonnel records revealed: 2/11/15 as a Medication				
	Staff B's personnel re no substantial finding -Her daily responsibil					
	-Staff B had worked to	staffing schedule revealed: en shifts in 2/11/15-2/28/15. eight shifts in 3/1/15-3/9/15.				
	Interview on 3/19/15 a	at 2:05 pm with Resident				

Division of Health Service Regulation

STATE FORM 8899 XBF311 If continuation sheet 32 of 37

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
HAL080020	B. WING		03/20	/2015
ENT OF DEFICIENCIES BT BE PRECEDED BY FULL SENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETE DATE
completing a HCPR byee. Deted a HCPR check uary 31, 2015. ed the job offer and ter she discarded the missing until she did a rch 9, 2015. R check on March 9, indings. working on the floor 15. 20/15 at 11:56 am with ation aide revealed: acility since 2/07/15 as a e night shift, and vening shift. shift with one personal d her paperwork when the forms had been	D 137			
ining On citation ining On citation ill have at least one ses at all times who has 24 months a course on ation and choking e Heimlich maneuver,	D 167			
The condition of the co	HAL080020 STREET ADDITION OF DEFICIENCIES THE PRECEDED BY FULL ENTIFYING INFORMATION) Completing a HCPR spee. Ideted a HCPR check ary 31, 2015. Ideted the job offer and er she discarded the missing until she did a sch 9, 2015. Incheck on March 9, andings. Invorking on the floor street of the properties of the p	A BUILDING:	DENTIFICATION NUMBER: HALO80020 STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SNO CROSS-REFERENCED TO THE APPR DEFICIENCY) D 137 D 137	DENTIFICATION NUMBER: HALO80020 STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023 NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION) D 137 D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 137 D 137 D 137 D PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 137 D 1

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 33 of 37

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			E SURVEY PLETED
		HAL080020	B. WING		03	3/20/2015
	ROVIDER OR SUPPLIER	TER 1114 SOU	DRESS, CITY, STA TH MAIN STREI OVE, NC 2802	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 167	First Aid, or by a train certification as a train from one of these org person trained accord access at all times in valve pocket mask for cardio-pulmonary res This Rule is not met TYPE B VIOLATION Based on record reviet facility failed to assure was on the premises within the past 24 more Resuscitation (CPR) from 3/1/15-3/19/15, adays on third shift from The findings are: A. Review of Staff B's -Staff B was hired as -No documentation of Review of the staff worked third: Personal Care Aide (Incertified). Review of the staff worked with a certified on third shift -2/12/15, 2/15/15/15/15/15/15/15/15/15/15/15/15/15/	Health Institute or Medic er with documented er on these procedures anizations. The staff ling to this Rule shall have the facility to a one-way ruse in performing uscitation. as evidenced by: ews and interviews, the extreme at least one staff person at all times that had training enths in Cardio-Pulmonary for 1 of 19 days on third shift and for seven of twenty eight extreme 2/1/15-2/28/15. Expersonnel file revealed: a Medication Aide on 2/9/15. CPR training. ork schedule taff B revealed: shift (3/16/15) with a epcA), whom was not CPR	D 167			

Division of Health Service Regulation

STATE FORM STATE FORM XBF311 If continuation sheet 34 of 37

STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			_		
		HAL080020	B. WING		03/20/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
		1114 SOUT	H MAIN STRE	FT	
CHINA GF	ROVE RETIREMENT CEN	TER	OVE, NC 2802		
			T 2002		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 167	Continued From page	e 34	D 167		
D 167	3/19/15 at 4:00 pm re- She thought Staff B I previous employerShe thought she had card in the personnel - The RCD was told by expired in 2014, but of from Staff B's previou - The facility sent staff and 3/13/15. Telephone interview of Staff B, Supervisor/M - She did not provide current CPR/choking out employment inform - She had worked at the medication aide She routinely worked occasionally worked the evenual cardial She worked the evenual cardial coming to the facility She had a CPR train was not able to located expiration of her train November 2014 No resident had be	evealed: had CPR training from I a copy of Staff B's CPR file. y Staff B that her CPR lid not get a copy of the card is employer. To a CPR class on 11/14/14 on 3/20/15 at 11:56 am with edication Aide revealed: the facility a copy of a certification when she filled mation. the facility since 2/07/15 as a d the night shift, and	D 167		
	3/19/15 as follows: - Immediately the Res (RCD) rearranged the one staff with a current - The RCD will make	a Plan of Protection on sident Care Coordinator e schedule to assure at least nt CPR was working. sure at least one staff ift had current CPR when			

Division of Health Service Regulation

making the schedule.

STATE FORM 6899 XBF311 If continuation sheet 35 of 37

PRINTED: 04/06/2015 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,			(X3) DATE SURVEY COMPLETED
		HAL080020	B. WING		03/20/2015
	ROVIDER OR SUPPLIER	STREET ADD 1114 SOUT	RESS, CITY, STA H MAIN STRE DVE, NC 2802	ET	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE COMPLETE
D 167	offer classes on vario staff attend. - The RCD will have (and available. CORRECTION DATE	all staff CPR certified and will us days to make sure all CPR certification in the files	D 167		
D912	D912 G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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.		D912		
	reviews, the facility fareceived care and set appropriate and in confederal and state laws related to staff training resuscitation requiremenvironment related to locked area when not by staff. The findings are: A. Based on record refacility failed to assure was on the premises.	n, interviews and record iled to assure residents rvices which are adequate, impliance with relevant is and rules and regulation ig on cardio-pulmonary inents and physical is chemicals not stored in a in use and not monitored eviews and interviews, the is at least one staff person at all times that had training			
	Resuscitation (CPR)	nths in Cardio-Pulmonary for 1 of 19 days on third shift and for seven of twenty eight			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 36 of 37 XBF311

PRINTED: 04/06/2015 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
HAL080020		B. WING		03	03/20/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1114 SOUTH MAIN STREET CHINA GROVE, NC 28023							
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	E ACTION SHOULD BE COMPLETE DATE DATE		
D912	days on third shift from Tag 0167, 10A NCAC Cardio-Pulmonary Reviolation).] B. Based on observed facility failed to assure residents (Resident # separate locked area monitored by staff and room (Room #102) wingested or inhaled.	m 2/1/15-2/28/15. [Refer to a 13F .0507 Training on esuscitation (Type B attion and interviews, the electronic	D912				

Division of Health Service Regulation

STATE FORM 6899 XBF311 If continuation sheet 37 of 37