	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		HAL045115	B. WING		12/17/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
CHERRY	SPRINGS VILLAGE		AR CREEK ROA SONVILLE, NC			
(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 APPROPI DEFICIENCY)	BE COMPLETE	
D 000	Initial Comments		D 000			
	conducted an annual investigation on Dece exit conference via te 2015. The complaint i	epartment of Social Services survey and complaint omber 15-16, 2015 with an lephone on December 17, investigation was initiated by y Department of Social				
D 206	10A NCAC 13F .0604 Other Staffing	(2b) Personal Care And	D 206			
	10A NCAC 13F .0604 Staff	Personal Care And Other				
		es the nature of the aide's vances and limitations:				
	between the hours of limited to occasional, wiping up a water spil attending to an individ	ng performed by an aide 7 a.m. and 9 p.m. shall be non-routine tasks, such as I to prevent an accident, dual resident's soiling of his dent make his bed. Routine hissible aide duty.				
	failed to assure any h an aide between the h limited to occasional, laundry and food serv	as evidenced by: nd record review, the facility ousekeeping performed by nours of 7am and 9pm was non-routine tasks related to rices duties on first and and Sunday and on second				
	The findings are:					
	Confidential interview Aides (PCAs) during t	s with 5 Personal Care the survey revealed:				

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

TITLE (X6) DATE

		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		D MING		С	
	HAL045115	B. WING		12/17/2015	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHERRY SPRINGS VILLAGE	358 CLEAR	CREEK ROAI	ס		
CHERRY SPRINGS VILLAGE	HENDERSO	ONVILLE, NC	28792		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 206 Continued From page 1		D 206			
-Two PCAs and two Medicusually scheduled to work -The laundry staff works Mon first shiftFirst and second shift PC weekendsSecond shift staff did laur -Resident laundry included clothes for residents on the with showers and included evening mealExtra laundry may be necessiled clothes and bed line -After the PCAs assisted a and dressing, they made to clean sheets, took all the linens, and towels from the washed, folded, and return resident roomsEach PCAs was assigned shift on first and second showeek-ends, but the number increase if the previous shift on first and second showeek-ends, but the number increase if the previous shown has physician ordered was only one PCA to assist -There were at least 17 resident some assist and dressingThere were at least a total required extensive assistat undressed and redressed assistance, and transfer at the eveningsOther personal care aide answering resident request otherwise and assisting resident request otherw	ca first and second shift. Monday through Friday CA's did laundry on the Indry daily. Individual dail linens, towels, and the day they are assisted did tablecloths for the Independent dail description of the dail description of the dail description of the description of the dail description	D 206			

Division of Health Service Regulation

-The staff had to open the coded doors for

STATE FORM 6899 1PEJ11 If continuation sheet 2 of 15

DIVISION	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	=1ED
					l c	
		HAL045115	B. WING		1	7/2015
		TIALU43113			12/1	112015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
OUEDDV (358 CLE	AR CREEK ROA	D		
CHERRY	SPRINGS VILLAGE	HENDER	SONVILLE, NC	28792		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 206	Continued From page	2	D 206			
		after management left the				
	-	eek days and all day on the				
	weekends.					
		included taking the residents				
		king the dirty dishes and				
		n, and laundering the table				
	clothes on second sh					
		cient PCAs to attend to the				
	resident's needs					
	-	ides on second shift and				
	-	I not take a meal break.				
	-	I continued to work during				
	the meal break.					
		o "undone" (frequency not				
	· ·	ift because they could not all				
	be done with all the o	·				
		are and dental care "suffer"				
	because the PCAs ca					
		it on second shift and it's				
	very hard to find staff	to hire for PCA duties.				
	0 61 611	M. A. P. G. A. I.				
		with a Medication Aide				
	revealed:	princed in at an the days we				
	-	missed just on the days we				
	are really short."	on some of the assend shift				
		nen some of the second shift				
		hifts two hours late, which				
	shift.	er floor staff working the				
		out because the residents				
	<u> </u>	e out because the residents r treatment, because we				
	don't have anybody [t					
		y hired new staff, but the				
	-	either during their training or				
	shortly thereafter.	Saler during their trailing of				
		peing short staffed on second				
	shift."	only short staned on second				
		d a half hours helping in the				
	dining room during su					
		lates, fill coffee and water for				
	- we neip pass out pi	iaico, iiii conce anu waiei iul	1			

Division of Health Service Regulation

STATE FORM 6899 1PEJ11 If continuation sheet 3 of 15

STATEMENT	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		C	
		HAL045115	B. WING		1	7/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHERRY	SPRINGS VILLAGE	358 CLEAR	CREEK ROA	D		
			ONVILLE, NC			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 206	Continued From page	3	D 206			
	residents, pickup plate and wash the tablecto	es, cleanup the dining room, ths after supper."				
	revealed the following -Monday: 9 showers -Tuesday: 10 showers -Wednesday: 8 shower -Thursday: 10 showers -Friday: 9 showers -Saturday: 8 showers -Sunday: 9 showers Confidential interview the survey revealed: -Two stated there was The facility was short-	s ers s				
	Saturday and Sunday -One stated "9/10th's' one aide taking care of -One stated it takes 5 call bells to be answe -One stated staff com be right back," and the -One stated her room in 7 days. (Roommate -Three of 6 residents lights timely"I can't remember the help with my shower." scheduled to receive s Saturday's on second Confidential interview member/guardians du	of the time there is only of the "entire house." minutes to an hour for the red. e in the room and say "I'll en come back an hour later. mate had not had a shower e could not remember.) stated staff answered call e last time staff came in to ' The resident was showers on Tuesdays and shift. with 3 resident family uring the survey revealed				
	they had no concerns care.	with residents' personal				

Division of Health Service Regulation

Confidential interview with a 4th resident family

STATE FORM 6899 1PEJ11 If continuation sheet 4 of 15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					C	;
		HAL045115	B. WING		1	7/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHERRY S	SPRINGS VILLAGE		R CREEK ROA ONVILLE, NC			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
D 206	Continued From page	e 4	D 206			
	staff were sometimes and if there were any week-ends." (This fan to not discuss any of Telephone interveiw v 12/17/15 at 2:00pm re-The laundry staff had week, six hours per d 1:00pm. One laundry staff wo could not do all the la-The facility has three three commercial drygers.	nily member/guardian chose the issues.) vith the Administrator on evealed: d been working 5 days per ay and left the facility at rking 30 hours per week undry for 56 residents. e commercial washers and ers. 5, the staff were informed				
D912	12/16/15 at 3:20pm revealed: -She had been inform Administrator that dire supposed to do house duties from 7:00am to -The facility currently worked 30 hours per valundry could not be of G.S. 131D-21(2) Decided G.S. 131D-21 Declar Every resident shall he 2. To receive care an adequate, appropriate	ect care staff were not ekeeping and food service of 9:00pm. In the staff which week and she knew all the completed in that time. Identify a staff which week and she knew all the completed in that time. Identify a staff which week and she knew all the completed in that time.	D912			

Division of Health Service Regulation

STATE FORM 6899 1PEJ11 If continuation sheet 5 of 15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					С		
		HAL045115	B. WING		12/17/2015		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CHERRY	SPRINGS VILLAGE		CREEK ROA ONVILLE, NC				
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	I (X5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPL	ETE	
D912	Continued From page	e 5	D912				
	reviews, the facility fa received care and ser appropriate, and in co	ns, interviews, and record iled to ensure residents rvices which were adequate, ompliance with relevant is and rules and regulations					
	Based on observation review, the facility fail Staff (Staff A, C, and 10/1/13 as Medication successfully complete administration training (Staff B) completed the Validation prior to administration to administration training (Staff B) completed the Validation prior to administration to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation prior to administration training (Staff B) completed the Validation training	ed the 15 hour medication g and 1 of 5 sampled Staff ne Medication Clinical Skills ministering medications. S. 131D-4.5B(b) Adult Care es Training and					
D935	Training and Competer G.S. § 131D-4.5B (b) Medication Aides; Translutation Requirement (b) Beginning Octobe home is prohibited from	Adult Care Home lining and Competency ents. r 1, 2013, an adult care om allowing staff to perform dication aide duties unless	D935				
	medication aide durin	g the previous 24 months in r successfully completed all					

Division of Health Service Regulation

STATE FORM 6899 1PEJ11 If continuation sheet 6 of 15

DIVISION	n Health Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	TED
					_	
			D WING		C	
		HAL045115	B. WING		12/17	/2015
NAME OF D	ROVIDER OR SUPPLIER	STREET AP	DRESS, CITY, STA	TE ZIP CODE		
. W WINE OF T	.SDER OR OUT LIER					
CHERRY S	SPRINGS VILLAGE		R CREEK ROA			
		HENDER	SONVILLE, NC	28792		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	XIAI E	DAIL
D935	Continued From page	e 6	D935			
	(1) A five-hour training	g program developed by the				
		ides training and instruction				
	in all of the following:	acc naming and mondoner				
	a. The key principles	of medication				
	administration.	or modication				
		rs for Disease Control and				
		s on infection control and, if				
	_					
	applicable, safe inject	•				
		oring or testing in which				
	-	e potential for bleeding				
	exists.					
	` '	aluation consistent with 10A				
		I 10A NCAC 13G .0503.				
	· ·	om the date of hire, the				
		completed the following:				
	a. An additional 10-ho	.				
		partment that includes				
	•	on in all of the following:				
	1. The key principles	of medication				
	administration.					
	2. The federal Center	s of Disease Control and				
	Prevention guidelines	on infection control and, if				
	applicable, safe inject	tion practices and				
		oring or testing in which				
	bleeding occurs or the	e potential for bleeding				
	exists.	-				
	b. An examination de	veloped and administered				
		alth Service Regulation in				
		section (c) of this section.				
		(,				
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION	as stractionally.				
	TILDVIOLATION					
	Based on charaction	n interview and record				
		n, interview and record				
		ed to assure 3 of 5 sampled				
	Staff (Staff A, C, and	E), who were hired after				

Division of Health Service Regulation

10/1/13 as Medication Aides (MA) had

STATE FORM 6899 1PEJ11 If continuation sheet 7 of 15

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
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		HAL045115	B. WING		1	7/2015
					1 12/1	72010
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CHERRY	SPRINGS VILLAGE		R CREEK ROAI			
		HENDERS	SONVILLE, NC	28792		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D935	Continued From page	e 7	D935			
	administration training (Staff B) completed the	ed the 15 hour medication g and 1 of 5 sampled Staff ne Medication Clinical Skills ministering medications.				
	record revealed: -She was hired 9/14/2 (MA)Staff A had successfined Test on 9/28/00Staff A had successfined Test on Clinical Sland There was no document Temployment Verificated There was no document to the test of th	ully completed the kills checklist on 9/16/15. nentation a Medication Aide				
	medication pass on 1 11:40am revealed the eyedrops, oral medica injection.	2/15/15 from 11:15am to e MA correctly administered				
	at 3:57pm revealed: -She currently worked first shiftShe had 10 to 12 year an MAShe had worked as a 4 years prior to comin facility.	d as a MA in the facility on ars experience working as an MA at another facility for ng to work at the current				
	12/16/15 at 11:15am	siness Office Manager on revealed:				

Division of Health Service Regulation

-Staff A was hired on 9/14/15 as a MA.

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		HAL045115	B. WING		12/17/2015
		11AL043113			12/11/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		358 CLE	AR CREEK ROA	D	
CHERRY	SPRINGS VILLAGE	HENDER	SONVILLE, NC	28792	
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-,
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D935	Continued From page	2 8	D935		
2000	Continued From page				
		s employment application,			
		another facility as a MA			
	prior to coming to wor	•			
	-A Medication Aide Er	mployment Verification was			
		ff A when she was hired.			
	-The Resident Care C	Coordinator (RCC) would			
	know if Staff A had re	ceived the 15 hour			
		ecause the RCC worked			
	with the Nurse Consu	Iltant to schedule required			
	medication training.				
	Refer to interview with	-			
	Consultant on 12/16/	15 at 11:52am.			
	Refer to interview with				
	Manager on 12/16/15	at 12:15pm.			
	Refer to interview with				
	Coordinator on 12/16	/15 at 12:45pm.			
	Defends into a decorda	- th A -lu-iu-itutu			
		h the Administrator on			
	12/16/15 at 5:00pm.				
	D. Dovious of Stoff Dia	norsonnal and training			
	record revealed:	s personnel and training			
	-She was rehired on 8	0/25/15 oo o MA			
		ented previous hire date of			
	4/25/12.	ented previous fille date of			
		ully passed the Medication			
	Aide Test on 8/22/07.				
	-Staff B had successf				
		kills checklist on 4/25/12.			
	-There was no docum				
		on Clinical Skills checklist			
	after being rehired on				
	_	ation Aide Employment			
		s completed on 10/18/13.			
	-There was no docum				
	completed a 5, 10, or				
	completed a 3, 10, 0f	15 Hour Meulcallon	1		

administration training.

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DIVISION	n nealth Service Regu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B. WING		С	
		HAL045115	B. WING		12/17	7/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			R CREEK ROA	•		
CHERRY	SPRINGS VILLAGE					
		HENDERS	ONVILLE, NC	28/92		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGULATORT OR E	100 IDENTIFY THE INTORNATION	TAG	DEFICIENCY)		
				,		
D935	Continued From page	9	D935			
	. •					
		siness Office Manager on				
	12/16/15 at 11:15am					
		nd a Medication Clinical				
	Skills Validation comp	pleted after the rehire date of				
	8/25/15 for Staff B in	the personnel record.				
	-"You will have to ask	the RCC about the				
	Medication Clinical SI	kills Validation," because the				
	RCC coordinates the	needed training with the				
	Nurse Consultant.	•				
	Interview with the faci	ility Nurse Consultant on				
	12/16/15 at 11:50am	-				
		ation Clinical Skills checklist				
		when Staff B was rehired on				
	8/25/15.	viieri etaii b was reniirea on				
		the exact date she had				
	completed the checkl					
	-"I don't keep copies,					
		ager's name and Resident				
	Care Coordinator's na	ame] the paperwork."				
		, MA, on 12/16/15 at 4:32pm				
	revealed:					
		se did a checkoff med list				
	with me in August who	en I came back" to work				
	here.					
	-The RN had her dem	nonstrate how to perform a				
	fingerstick blood suga	ar testing and demonstrate				
	how to draw up insulin	n.				
	-The RN also gave a	"prepouring lecture" to				
	advise Staff B not to p					
		ook at actual prescriptions				
		s to get those prescriptions				
	to the facility pharmac					
		taff B on the importance and				
		tion orders with physicians.				
		to explain how to catch a				
	- The Kin Teally lifes t	to explain now to catch a				

Division of Health Service Regulation

-The RN also did go over diabetic care with Staff

STATE FORM 6899 1PEJ11 If continuation sheet 10 of 15

<u>Division c</u>	Division of Health Service Regulation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL045115	B. WING		C 42/47/2045
		MALU45115			12/17/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
2::=DDV/		358 CLE	AR CREEK ROA	D	
CHERRY	SPRINGS VILLAGE	HENDER	SONVILLE, NC	28792	
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE DATE
				DEI IGIENOT)	
D935	Continued From page	e 10	D935		
	B including the sympt	toms of hypo and			
		eaction times of various			
	insulins.				
	-Staff B had been a M	Medication Aide at a local			
	assisted living facility	from late 2010 to June			
	2011.				
	r				
	Refer to interview with	•			
	Consultant on 12/16/	15 at 11:52am.			
		5			
	Refer to interview with				
	Manager on 12/16/15	at 12:15pm.			
	Refer to interview with	h the Besident Care			
	Coordinator on 12/16	/15 at 12.45pm.			
	Refer to interview with	h the Administrator on			
	12/16/15 at 5:00pm.	II the Administrator on			
	12/10/10 at 0.00p				
	C. Review of Staff C's	s personnel and training			
	record revealed:	- P-1-1-1			
		11/14 as a Personal Care			
	Aide and then was pr	romoted to MA on 12/2/15.			
		fully passed the Medication			
	Aide Test on 6/5/12.				
	-Staff C had successf				
	Medication Clinical SI	kills checklist on 6/18/14.			
		nentation a Medication Aide			
	Employment Verificat	•			
		nentation Staff A completed			
		edication administration			
	training.				
	Lindamiass sidh tha Des	sinoso Office Manager on			
	12/16/15 at 11:15am	siness Office Manager on			
		's employment application,			
		t another facility as a MA			
	prior to coming to wor	mployment Verification was			
		aff C when she was hired.			
	not completed for Sta	ili C when she was hired.			

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Bivioloti	i Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
		HAL045115	B. WING		12/17/2015
			•		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
0115551		358 CLEA	R CREEK ROA	D	
CHERRY	SPRINGS VILLAGE	HENDERS	ONVILLE, NC	28792	
	OLIMANA DV. OT.		 		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
IAG		,	IAG	DEFICIENCY)	
D935	Continued From page	e 11	D935		
		Coordinator (RCC) would			
	know if Staff C had re	ceived the 15 hour			
	medication training, b	ecause the RCC worked			
		Iltant to schedule required			
	medication training.	mant to concurre to quite			
	medication training.				
	Attamanta di talambana	intomicus with Ctaff C			
		interview with Staff C, on			
	12/16/15 at 3:59pm w	as unsuccessful by exit.			
	Refer to interview with	n the facility Nurse			
	Consultant on 12/16/1	15 at 11:52am.			
	Refer to interview with	n the Rusiness Office			
	Manager on 12/16/15				
	Ivialiagei oli 12/10/13	at 12.15piii.			
	56666				
	Refer to interview with				
	Coordinator on 12/16/	/15 at 12:45pm.			
	Refer to interview with	n the Administrator on			
	12/16/15 at 5:00pm.				
	'				
	D. Review of Staff F's	s personnel and training			
	record revealed:	personner and training			
		IF Madiantian Aida			
		15 as a Medication Aide			
	(MA).				
	 Staff E had successf 	ully passed the Medication			
	Aide Test on 11/24/15	5.			
	-Staff E had successf	ully completed the			
		kills checklist on 10/21/15.			
	-There was no docum				
	completed a 5, 10, or				
	administration training				
	administer medication	is.			
	Review of five sample	ed residents November			
	2015 Medication Adm				
	revealed:				
	-Staff E administered	an cintment and two			
		ions to 2 of 5 sampled			

Division of Health Service Regulation

residents (Resident #1 and #4) on the following

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED							
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:							
					С						
		HAL045115	B. WING		12/17/2015						
					1 12/11/2010						
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE							
CHERRY SPRINGS VILLAGE 358 CLEAR CREEK ROAD											
		HENDERS	SONVILLE, NC	28792							
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE						
D935	Continued From page	e 12	D935								
	dates: 11/6/15 11/7/1	5 11/13/15 11/14/15									
	dates: 11/6/15, 11/7/15, 11/13/15, 11/14/15, 11/20/15, 11/21/15, and 11/28/15.										
		, MA, on 12/16/15 at 8:09am									
	revealed: -She primarily worked	d on third shift as a									
	Medication Aide and I										
		cations that were routinely									
		ents at the 6am medication									
	pass by the third shift medication aides.										
		n another Medication Aide on									
	the medication cart "for 3 or 4 weeks" before being allowed to administer medications on her										
	own.										
	Interview with the Bus	siness Office Manager on									
		Coordinator (RCC) would									
	know if Staff E had re	, ,									
		ecause the RCC worked									
		ıltant to schedule required									
	medication training.										
	Refer to interview with	h the facility Nurse									
	Consultant on 12/16/	15 at 11:52am.									
	D 6 4 1 4 1 1 11										
	Refer to interview with Manager on 12/16/15										
	Manager on 12/10/13	o at 12.19pm.									
	Refer to interview with	h the Resident Care									
	Coordinator on 12/16	/15 at 12:45pm.									
		h the Administrator on									
	12/16/15 at 5:00pm.										
	-										
		ility Nurse Consultant on									
	12/16/15 at 11:52am										
		hour medication course."									
	- i triirik triey do the 1	5 hour medication class			[

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Division of Health Service Regulation										
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
ANDILAR	JF CONNECTION	IDENTII IOATION NOMBER.	A. BUILDING:		OOWII LETED					
		1141 645445	B. WING		C					
		HAL045115	B. WIITO		12/17/2015					
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATI							
CHERRY	SPRINGS VILLAGE		AR CREEK ROAD							
			SONVILLE, NC 2							
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /					
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR						
				DEFICIENCY)						
D935	Continued From page	e 13	D935							
	online or something."	ı								
		siness Office Manager on								
	12/16/15 at 12:15pm -The Administrator, the									
		self were responsible for the								
		re MAs had the required								
		eived the required training								
		idminister medications in the								
	facility.									
		ew hires after 10/1/13 were								
	required to have either	tion form in the personnel file								
		naving completed the 5,10,								
		dministration training prior to								
		ations in the facility, or								
		r medication training within								
	60 days of date of hireShe had never seen an Medication Aide									
		tion Form and was unaware								
	of the requirement to									
	·									
		sident Care Coordinator on								
	12/16/15 at 12:45pm									
	verification for Medica	heard of any employment ation Aides "								
	-"If it's my responsibil									
		tor was "supposed to set up								
		n the computer to do the 5,								
	10, or 15 hour medica	ation training course."								
	Interview with the Adr	ministrator on 12/16/15 at								
	5:00pm revealed:	Timistrator on 12/10/10 at								
		e the new Administrator for								
	the facility on 11/9/15									
		tor had left one week prior to								
	11/9/15.									
ļ	_l -Sne nad aiready nad	d her staff begin to audit all of								

the MA's personnel records that afternoon to ensure qualifications and training were complete.

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A. BUILDING:	С										
HAL045115 B. WING	12/17/2015										
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
CHERRY SPRINGS VILLAGE 358 CLEAR CREEK ROAD											
HENDERSONVILLE, NC 28792											
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CC PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE										
D935 Continued From page 14 D935											
Continued From page 14 -She had already spoken with a Registered Nurse that afternoon to schedule the required 15 hour medication training class for Staff A, C, and E that would be needed if she was unable to obtain Employment Verfications from their previous employers. -The facility Nurse Consultant was performing a Medication Administration Clinical Skills Validation with Staff B "at 5:00 o'clock today." A plan of protection was received from the facility on 12/16/15 and included the following: -Peer support providing immediate employee file audits on all employee files to assure Medication Aide employment verification has been obtained or the state required 5, 10, 15 hour medication training has been provided when appropriateA Medication Clinical Skills Validation performed by a Registered Nurse will be completed on all new hire Medication Aides before the Medication Aides are allowed to administer medications. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2016.											

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