STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034098	A. BUILDING: _____ B. WING _____	C 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM TERRACE	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Forsyth Country Department of Social Services conducted an annual survey and complaint investigation on 4/05/16-4/07/16. The complaint investigation was initiated by the Forsyth County Department of Social Services on 4/01/16.	D 000		
D 072	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure the outside grounds of the facility and building were maintained in a clean and safe condition. The findings are: Observation of the outside grounds surrounding the facility on 4/07/16 beginning at 10:50 am through 11:30 am revealed the following (going in a clockwise pattern starting on the right exiting the facility): -The front outside wall of the Special Care Unit (SCU) had dark mold (approximately 8" x 3') growing outside of a side door. -An opening approximately 8"x 12" on the roof overhang to the immediate right of the entrance	D 072		

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D 072	Continued From page 1	D 072		

wall to the facility. The missing vent cover was found on a nearby Air Conditioning (AC) unit.
-One pane of a double paned window of the SCU dining room was missing with broken glass shards around the window edges, on the lower edge of the window frame, and on the ground. The inside pane of the window glass appeared intact.
-Black fuzzy mold was around 3 outside AC units, including ones near the right and left entrance to the facility.
-A piece of cloth fabric was sticking out of the hole surrounding an exposed but capped pipe. The fabric draped to the ground.
-The trim (fascia board) around the edge of the roof was separated and falling off in numerous places including the outside front, the left and right side of the front of the facility, several places at the back side of the SCU, and several places on the right side of the facility. In several places it was loose and hanging down, and in other places it was lying on the ground.
-The fascia board on the left of the facility outside the memory care pod was totally off and found on the ground in front of bushes. It had sharp metal edges on the left side that was facing up.
-Six-feet of irrigation tubing was exposed near a tree in the back of the facility behind the SCU creating a possible tripping hazard.
-Gutters in the rear of the facility were full of leaves.
-There were two large blue tarps over two different areas of the middle of the building.
-A free-standing AC unit and numerous wooden pallets were on the ground outside of the diesel fuel storage area.
-Three paint thinner containers (one empty, one full, and one 1/2 full) were on a movable metal shelving rack against a wall in a fenced-in patio area outside "The Terrace Room" at the end of

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D 072	Continued From page 2	D 072		

the 100 hall of the Assisted Living (AL) Unit. Four concrete containers with cigarette butts were on this patio, although a "No smoking" sign was posted. The nearest container was approximately 3 feet from the paint thinner containers. No staff or residents were observed smoking here.
-Tree debris, and metal bedframe pieces were in two piles around the dumpster area
-The wooden framing and fascia around the roof was falling apart in the smoking area at the side of the AL unit. It was hanging down and had rotten areas.
-The framing and fascia on the front of the building had fallen off (on the right when facing the building).
-The wooden frame around the facility had separated and was falling down. It had areas of rotted wood.
-A light bulb was found on the front sidewalk of the facility and was discarded by the survey team.
-The front unit area had dark green to black mold on the wall at an exit door outside the AL resident corridor.
-The front of the building had dark green to black mold and part of the roof had rotted wood and was falling down.
-Paper trash and empty soda cans were on the ground in the residents' smoking area.
-Mold was growing on the wall beside the front door under the fire department access pipe.

Observation of the patio outside the "Terrace Room" at the end of the AL 100 hall on 4/07/16 at 5:15 pm revealed the paint thinner containers had been removed.

Interview on 4/05/16 at 11:48 am with the Maintenance Supervisor revealed:
-The facility roof was in need of replacing in various areas.

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D 072	Continued From page 3	D 072		

-He had obtained an estimate to repair the entire roof approximately one year ago.
-The facility owners had opted to repair the facility roof in sections.
-He had not been given approval to have the 100 Hall AL roof replaced.

Interview on 4/07/16 at 1:00 pm with a housekeeper revealed:
-The housekeeping staff swept the outside of the facility including the parking lots at the start of each shift.
-At the start of their shift, the housekeeping staff emptied trash from the outside of the building, including the resident and employee smoking areas.

Interview on 4/07/16 at 1:05 pm with the Environmental Service Coordinator revealed:
-He had worked at the facility for 2 years.
-The housekeeping staff swept the outside of the building, and picked up trash in the common areas at the start of the each shift.
-Second shift was responsible for cleaning up trash in the parking lot, dumpster and smoking areas.

Interview on 4/07/16 at 3:10 pm with the Assistant Maintenance Director revealed:
-The paint thinners had been on the outside shelving rack for "about one week" since there was painting in progress and "they smelled so bad". He would remove them after our conversation.
-The roof repairs or replacement was being handled by the Administrator and the owners.
-The roof had been an issue for "about 9 years", roofers have come out and said that it could not be patched anymore, that "it would create more problems by walking on it". (A date was not

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D 072	Continued From page 4 specified by him for when the roofers came out to give an estimate.) -The maintenance department did a "safety walk through" 3 times per week, but it was more for the inside of the building. This was logged on a "safety monitoring sheet" and placed in a book kept in the maintenance office. Observation of the maintenance log book on 4/07/16 at 3:10 pm revealed rounds by the maintenance staff were completed and documented on a "safety monitoring sheet" 3 times per week for the month of March and 2 times for the first week of April. Interview on 4/07/16 with the Administrator revealed: -The maintenance staff did a walk through of the building 3 times per week to see if things needed repair or replacement, especially in the SCU since the AL residents could report if things were broken. -Maintenance was also to monitor the outside of the facility. -The housekeeping staff swept and emptied trash in the courtyards. -The area with the paint thinners was not a designated smoking area. The concrete containers were "planters, not cigarette butt receptacles. No one should be smoking there. There was a no smoking sign posted."	D 072		
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	D 074		

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D 074	Continued From page 5 coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings and floors were kept clean and in good repair as evidenced by the Assisted Living (AL) corridors and residents' rooms (#104, #115) had water damage stains (AL hallway 100, AL hallway 200, and facility entrance hallway), and damaged and missing floor tiles and caulking in the common and handicapped bathroom on the 200 hall in the AL unit, and the staff bathroom at the AL nurses station. The findings are: Review of the current environmental health report dated 6/09/2015 revealed: -An overall score of 84. -A two point demerit in the category of floors, walls and ceilings, subcategory "floors easy to clean", with additional comments of "repair floors...where floors are no longer easily cleanable such as separated floor tiles". -A one point demerit in the category of floors, walls and ceilings, subcategory "walls and ceilings cleanable, clean, good repair, with additional comments of "wall damage throughout... repair ceiling damage...repair baseboard damage throughout". Observations on 4/05/16 at 10:05 am of the common bathroom on 200 hall revealed: -The interior wall on the right side had ¼ inch to ½ inch crack between the floor tiles and the wall running approximately 6 feet along the junction. -The interior wall baseboard, to the left of the sink, was missing 2 baseboard tiles. -The left corner of the wall opposite the entrance	D 074		

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D 074	Continued From page 6 door had a build-up of black mold approximately ½ inch wide between the wall and the floor extending out 4 feet from the corner towards the center of the wall. Observations on 4/05/16 at 10:05 am of the handicapped bathroom on the 200 hall revealed: -The door to the bathroom sagged. -The ceiling had an area approximately 12 inches long and 3 inches wide in the corner that had paint peeling and cracking. Observation on 4/05/16 at 11:00 am of the staff bathroom inside the locker room on the 100 hallway revealed: -The sink was loose and had loose, broken caulking at the top of the sink where it connected to the wall. -Underneath the sink was an open hole with the sink pipes protruding. -Cracked and broken floor tiles at the left corner of the floor under the sink. Observations of the perimeter of the facility on 4/07/16 from 10:50 am to 11:30 am revealed two large blue tarps visible on the roof top. Observations of the interior of the facility on 4/07/16 at 11:30 am revealed: -The 100 hall ceiling had numerous water spot discolorations of various sizes on the ceiling in the main hallway. -A thin crack in the 100 hall ceiling approximately 3 feet long starting from the edge of the wall and ending at the middle of the hallway ceiling. -Two water stains on the ceiling near the intercom box and sprinkler head outside room 100. -Numerous patched and painted areas on the ceilings throughout the facility over stains and crack repairs.	D 074		

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D 074	Continued From page 7 -The 200 hall nursing station had a large (approximately 2 feet by 3 feet) patched and repainted area on the ceiling over the counter area extending over the hallway. It had a new water stain at the narrow edge farthest from the front door of the facility. -Room #115 had a 2 feet by 8 feet section of drywall on the right wall behind the resident's bed. It had not been repainted after the wall repair. In this drywall section was a double outlet at the foot of the resident's bed without a cover. A portable fan was plugged into the outlet. -Room #104 had numerous water stains on the ceiling, including a 15 inch circular stain over the head of the bed nearest the door, a 2 inch by 12 inch stain on the left about 2 feet away from the sprinkler head, and at least 11 miscellaneous sized stains on the ceiling mostly on the farthest side of the room. There was also a narrow crack in the ceiling approximately 3 to 4 feet long from the edge of the wall towards the center of the ceiling. -A 8 inch round water stain on the ceiling outside the Resident Care Director's office. It also had popcorn finishing texture fallen off about 3 inches from the edge of the stain. There was also a 1/4 inch black dot in the center of the stain. It was not apparent if this dot was a hole or not. Observation of the maintenance log book containing the "safety monitoring sheet" on 4/07/16 at 3:10 pm revealed safety rounds were documented as done 3 times per week with findings documented that included burned out light bulbs that needed replacement and documented as replaced that day. Interviews on 4/05/16 at 11:10 am and 11:48 am with the Maintenance Director revealed: -He was in charge of repairs to the facility.	D 074		

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D 074	Continued From page 8 -He had been remodeling rooms in the facility one at a time for several months. -He was not aware of any bathroom that was not in good working order. -The facility roof was in need of replacing in various areas. -He obtained an estimate to repair the entire roof approximately one year ago. -The facility owners had opted to repair the facility roof in sections. -He had placed a large blue tarp over part of the 100 hall roof in order to help prevent leaks that were showing up in the ceilings in various areas of the 100 hall. -The building owners were aware the roof was leaking in areas of the building but he had not been given approval to have the 100 hall roof replaced. Interview on 4/07/16 at 2:50 pm with the residents residing in room 115 revealed: -The missing outlet cover and unpainted drywall section "had been that way ever since they moved in", at least 8 months. -The missing outlet cover did not bother them as they still plugged their fan into the outlet. -They had not reported the missing outlet cover or unfinished dry wall to anyone. Interview on 4/07/16 at 3:00 pm with a resident revealed: -The facility was slow to repair things. -"The roof was shot and needed to be replaced. All they (the facility staff) did was put up a tarp." -The roof had been "leaking into his room recently" (could not specify when), and he reported it to staff. Interview on 4/07/16 at 3:10 pm with a Maintenance Assistant revealed:	D 074		

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D 074	Continued From page 9 -He performed a safety walk through 3 times per week and documented his findings on a "safety monitoring sheet". These were kept in a log book in the maintenance office. -The roof and water leaks had been an issue for about 9 years. -The Administrator and the owners were handling the roof issue. -Roofers had come out to give estimates for work, and had said it "made no sense to patch it (the roof) because it would create problems walking on the roof". A confidential interview with a resident on 4/07/16 revealed a water spot in the hallway outside the Resident Care Director's office had leaked with last night's storm (4/06/16). Interview on 4/07/16 at 4:40 pm with the Administrator revealed: -The back portion of the facility's roof had been replaced. The corporate office was working to get financing in place to replace the rest of the roof. -There were two large blue tarps on the roof; one over the office area and one over the AL 100 hall of the facility. -The maintenance department did walk throughs 3 times/week, especially in the Memory Care Unit where the residents could not report repair needs. -She expected the facility's maintenance department to perform the fixable repairs as soon as possible after they were reported.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall:	D 076		

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D 076	Continued From page 10 (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to maintain furniture clean and in good repair as evidenced by torn sofas in the Special Care Unit (SCU) Family Room, and a broken air conditioning (AC) cover in room #312. The findings are: Observations during facility tour on 4/07/16 at 11:00 am revealed: -The two leather sofas in the SCU family room were torn with holes. The largest hole on one sofa was approximately 6 inches with stuffing visible at the front top edge of the sofa seating area. The second sofa had 4 cracks in the leather covering with several small (2-3 inch) holes in the top edge of the sofa seating area. -The AC unit cover was off in room #312, and was located on top of the closet. The unit was located parallel to the bed and directly under the window. Interview on 4/07/16 at 3:00 pm with the SCU Director revealed: -The resident in room #312 removed the AC cover every time the cover was replaced. -She would contact the maintenance department to replace the AC cover. -The torn sofas were reported at a management meeting, but she was not sure when. They were currently looking for suitable replacements. -Any patches made to repair the sofas had not worked as residents sat on the sofas and "picked at the holes and made them larger".	D 076		

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D 076	Continued From page 11 Interview on 4/07/16 at 3:10 pm with the Assistant Maintenance Director revealed: -Staff were to report repair needs to the maintenance department either by a telephone call or by reporting needs in a maintenance log book. -He was aware that the resident in room #312 frequently removed the ac unit cover. -He was aware of the holes in the sofa in the SCU. They had been patched without success as the residents "picked at the patches or holes and made them bigger". Interview on 4/07/16 at 4:40 pm with the Administrator revealed: -The facility management had been looking for replacement sofas for the SCU for the past few months. -She expected staff to report repair needs to the maintenance department. There were log books for staff to use if it was after hours. Review of the maintenance log book revealed: -Staff entries for repair needs, such as a toilet stopped up, were documented on a "service request sheet". -The entries included date/time entered, who reported the problem, and a space for date/time the need was repaired or addressed. -The entries in the log book were documented as repaired or addressed within 1 to 2 days of being reported. Review of the local Environmental Health annual inspection report dated 6/09/15 revealed: -A score of 84. -A demerit for furniture not being clean and in good repair.	D 076		

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D 076	Continued From page 12 Interviews with 2 family members of SCU residents revealed no dissatisfaction with the surroundings or care of the residents. Based on observations and interviews with staff on 4/7/16, it was determined the SCU residents were not interviewable regarding the holes in the sofas. Based on observations and interviews with staff, and attempted interview with the resident in room #312 on 4/07/16, it was determined the resident was not interviewable. He did not know why he removed the AC cover in his room.	D 076		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain a sanitation score of 85 or above at all times. The findings are: Observation on 4/05/16 at 9:15 am upon entrance	D 077		

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D 077	Continued From page 13	D 077		

to the facility revealed the sanitation score was 84 based on a local Environmental Health inspection completed on 06/09/15.

Review of the facility's current Environmental Health inspection report dated 06/09/15 revealed the inspection included demerits related to furniture,walls, floors, lighting, toilet, vermin control, proper disinfectant use, removal of solid waste and vacuum breakers missing on shower heads.

Observations on 4/05/16 at 10:05 am of the common bathroom on 200 hall revealed:
-The interior wall on the right side had ¼ inch to ½ inch crack between the floor tiles and the wall running approximately 6 feet along the junction.
-The interior wall baseboard, to the left of the sink, was missing 2 baseboard tiles.
-The left corner of the wall opposite the entrance door had a build-up of black mold approximately ½ inch wide between the wall and the floor extending out 4 feet from the corner towards the center of the wall.

Observation on 4/07/16 at 11:00 am of the rooms noted on the Environmental Health Inspection report revealed:
-The rooms were 106, 112, 514, 509, 505, 501, 502, 400, 407, 402, 405, 312, 310, 304, 203, 206.
-The findings had been corrected and/or were under repair.
-The door to room #112 stuck and did not close all the way.

Observation on 4/07/16 at 11:00 am of the furniture in the facility noted on the Environmental Health Inspection report revealed the two sofas in the Special Care Unit (SCU) family room had several holes at the front edge of the sofa sitting

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D 077	Continued From page 14 area. The largest was approximately 6 inches with stuffing visible. Interview on 4/05/16 at 10:45 am with the Administrator revealed: -She was aware of the sanitation score of 84. -The findings had been corrected and/or were under repair. -At the December 2015 staff meeting, the Maintenance Director was assigned to call the local Environmental Health Department to return to the facility for a reinspection. -She was not aware until today (4/06/16) that the local Environmental Health Department had not been contacted to return to the facility for a reinspection. She thought they were "running behind". -She was aware the facility had been given a deficiency for the score of 84 at their last annual survey on 6/24/15. Interview on 4/05/16 at 11:00 am with the Maintenance Director revealed: - The local Environmental Health Inspector had stated that he would return to the facility and conduct another inspection when the Maintenance Director called and advised him that the repairs had been made. This would possibly result in an increased sanitation score. -It was discussed "a while back" at a staff meeting about calling the local Environmental Health Department (for a re-inspection), but "I knew we were working on things at that time and were not ready, so I did not call them". "I'm sure I told the Administrator." -The facility employed one full-time maintenance employee and one part-time maintenance employee. -"Our department" had corrected or were working on the findings in the sanitation report. "The	D 077		

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Housekeeping Department" (Environmental Services Department) had issues cited on the sanitation report also that "I could not comment on".
-He was in charge of repairs to the facility.
-He had been remodeling rooms in the facility one at a time for the past several months.

Interview on 4/05/16 at 11:48 am with the Maintenance Director revealed:
-The facility roof was in need of replacing in various areas.
-He obtained an estimate to repair the entire roof approximately one year ago.
-The facility owners had opted to repair the facility roof in sections. The back portion of the roof had been replaced (date was not specified).
-He had placed a large blue tarp over part of the 100 Hall roof in order to help prevent leaks that were showing up in the ceilings in various areas of the 100 Hall.
-The building owners were aware the roof was leaking in areas of the building, but he had not been given approval to have the 100 Hall roof replaced.

Interview on 4/07/16 at 1:00 pm with the Environmental Services Coordinator (ESC) revealed:
-After the local Environmental Health Department inspection, "our department corrected everything within a week working off the list of deficiencies cited".
-The Maintenance Director or the Administrator would be responsible for calling the local Environmental Health Department to request a re-inspection.

Interview on 4/07/16 at 1:20 pm with the local Environmental Health Department representative

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revealed as of this date (April 7, 2016), no request had been made by the facility for a follow-up inspection.

Interview on 4/07/16 at 2:50 pm with 2 residents residing in room #115 revealed:
-A double outlet cover was missing in a replaced but not repainted 2 foot by 8 foot section of drywall behind the bed. A portable fan was plugged into the outlet.
-Both the residents said "it had been that way ever since they moved in". (One resident said he had moved in about 8 months ago, the other resident could not remember when he had moved in.)
-The missing outlet cover did not bother them as they still plugged their fan into the outlet.
-They had not reported the missing outlet cover or unfinished dry wall to anyone.

Interview on 4/07/16 at 3:00 pm with a third resident revealed:
-The facility was slow to repair things.
-"The roof was shot and needed to be replaced. All they (the facility staff) did was put up a tarp."
-The roof had been "leaking into his room recently (could not specify when), but not with last night's rain storm".

Interview on 4/07/16 at 4:40 pm with the Administrator revealed:
-The ESC contacted the local Environmental Health Inspector today for a re-inspection, and left a message.
-She was worried about contacting the local Environmental Health Inspector too soon before all the findings were corrected because it was "double the points for any uncorrected citings".
-She was aware of the SCU sofas needing to be replaced and was actively looking for

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D 077	Continued From page 17 replacements. -The back portion of the facility's roof had been replaced. The corporate office was working to get financing in place to repair the rest of the roof. -There were two tarps on the roof; one over the office area and one over the 100 hall of the facility.	D 077		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that treatment orders for wound care dressings were maintained in the resident's record in the facility for 1 of 7 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 3/30/16 revealed: -Diagnoses of diabetes mellitus and atherosclerosis of autologous vein bypass graft on lower right leg. -Orders for dry dressing changes to front thigh, silver alginate dressings every other day and dankins solution with dry dressing change daily. Review of an Encounter Form from the Wound Care Center dated 11/11/2015 revealed diagnoses of left above the knee amputation, peripheral artery disease, peripheral vascular	D 345		

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disease and delayed wound healing.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 9/16/13.

Review of Resident #3's Appointment Referral Forms revealed:
-A podiatrist's order dated 7/01/15 to apply topical antibiotic ointment to 5th right toe daily for seven days and to dress right great toe daily.
-A podiatrist's order dated 8/25/15 to continue wound care to right great toe daily.
-A podiatrist's order dated 9/11/15 to continue dressing changes to right toe daily.
-A podiatrist's order dated 9/29/15 to dress right toe daily.
-A podiatrist's order dated 10/12/15 to continue dressing changes daily using calcium alginate.
-A podiatrist's order dated 11/02/15 to clean and change dressing twice daily until healed.

Review of the Medication Administration Records from July 2015 through November 2015 revealed that there were no entries for wound care.

Review of Home Health Nurses notes in Resident #3's record revealed:
-Home Health Nurse (HHN) provided unspecified wound care to right great toe on 7/14/15.
-HHN provided wound care to right great toe utilizing hydrogel, gauze and tape on 7/20/15, 7/22/15, 7/24/15, 7/27/15, 7/29/15, 8/12/15, 8/14/15, 8/17/15, 8/19/15, 8/21/15, 9/08/15, 9/09/15, 9/11/15, 9/14/15, 9/16/15.
-HHN provided wound care to right great toe utilizing Santyl ointment and a calcium alginate dressing on 10/02/15, 10/05/15, 10/09/15, 10/28/15, 10/30/15.
-HHN provided wound care to right great toenail

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bed, tip and bottom of 4th toe and documented appearance of 4th toe being "angry looking" on 11/02/15.
-HHN found dressing to 4th toe to be off and provided wound care to right great and 4th toe and "clarifying orders" on 11/03/15.
-HHN provided wound care to the right great and 4th toe on 11/06/15, no description of dressing provided.

Review of Resident #3's Record revealed Resident #3 was admitted to the hospital on 11/11/15 for non-healing ulcers and early gangrene of the toes on the right foot, with severe peripheral vascular disease and diabetes mellitus and was admitted to a rehabilitation facility on 1/27/16.

Review of the Vascular Surgeon History and Physical dated 11/11/15 revealed:
-Resident #3 was seen in consultation for a non-healing ulcer of the right fourth toe after a trauma wound that occurred about three weeks prior.
-Resident #3 was admitted for an angiogram, but Resident #3 was advised that this physician thought that "the chances of limb salvage are very poor. Will probably require a right above the knee amputation."

Interview with Resident Care Director (RCD) on 4/07/16 at 11:51 am revealed:
-She had only been in this position for about one month.
-She expected that any order home health had clarified or new orders they had obtained would be faxed to the facility.
-If the HHN obtained an order while at the facility she expected the nurse to write the order on one of the facility order forms and then the facility

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would fax the physician for a signature.
-She did not know why the orders Home Health implemented were not in Resident #3's record.

Interview with the Administrator on 4/07/16 at 11:25 am revealed:
-She expected the Home Health agency would obtain orders, make recommendations and clarify orders accordingly.
-The facility expected the Home Health agency to get the orders changed so the Home Health agency had the orders the home health nurses were able to implement.
-The facility had been making the assumption that the Home Health agency was providing the wound care ordered and no one was checking to make sure the wound care was being done.
-She was not aware Home Health nurse was obtaining and implementing orders without making facility staff aware and without assuring that the orders were in the record.

Interview with a representative from the Home Health agency on 4/06/15 at 2:25 pm revealed:
-It was the responsibility of the facility to notify the Home Health agency of any new orders or order changes.
-The orders were typically faxed to the Home Health agency's office.
-If the Home Health agency could not implement the order due to frequency they would contact the physician for order changes.
-The Home Health agency could only take orders from one physician and if there were more than one physician involved they would get all orders clarified by one physician which was usually the primary care physician.
-If an order was unclear or vague the Home Health agency would call for clarification.
-The Home Health agency did not fax the facility

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the new orders or clarification of orders that were obtained from the physician.
-If there were clean dressing changes the Home Health agency's supervisor would expect the facility would implement such as applying topical antibiotic ointment or basic, daily clean dressing changes.
-The Home Health agency's responsibility was to get the orders changed or clarified and put into their system for their nurses to implement.
-The visiting nurses likely communicated the order changes during their visits, but she was not sure how exactly the facility obtained the orders for Resident #3's record.

Interview with Resident #3's Podiatrist on 4/06/16 at 6:39 pm revealed:
-The Physician thought the orders he wrote were being implemented as written.
-He was unaware the Home Health agency was having the orders clarified or changed through other physicians.
-He expected the facility to contact his office and report that there was more than one physician issuing orders or ask him for clarification if the orders he wrote were not clear or vague.
-The facility had not contacted his office for order changes or clarification that he was aware of.

Interview with Resident #3 on 4/06/16 at 4:16 pm revealed:
-The facility staff put a band-aid on her toe only one time.
-The facility staff did not normally provide wound care and the wound care was administered by a HHN.
-There was not a nurse employed by the facility that ever looked at her wound or that provided dressing changes.
-Resident #3's dressing came off once and a

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D 345	Continued From page 22 Medication Aide told her she would not dress her toe because that would be "crossing the Home Health agency's lines". Resident #3 could not recall when this occurred. -Resident #3 had to wait until the HHN came in the next time with her toe exposed, without a dressing for a day or two.	D 345		
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. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to the use of finger stick lancing pens for diabetic residents. The findings are: Based on observation, interview, and record review, the facility failed to assure infection control procedures were implemented in accordance with the Center for Disease Control's recommendation related to the use of finger stick lancing pens for diabetic residents during finger stick blood sugar (FSBS) checks for 1 of 1 sampled residents (Resident #8) and nine unlabeled lancing pens stored on medication	D912		

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D912	Continued From page 23 carts. [Refer to Tag 932, G.S. 131D-4.4A (b). (Type A2 Violation)].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions. e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the	D932		

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D932	Continued From page 24	D932		

facility's infection control policy.
(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observation, interview, and record review, the facility failed to assure infection control procedures were implemented in accordance with the Center for Disease Control's recommendation related to the use of finger stick lancing pens for diabetic residents during finger stick blood sugar (FSBS) checks for 1 of 1 sampled residents (Resident #8) and nine unlabeled lancing pens stored on medication carts.

The findings are:

Review of Resident #8's current FL-2 dated 3/23/16 revealed:
-Diagnosis included hypertension, middle cerebral artery stenosis bilateral, and diabetes mellitus.
-An order for FSBS at 7:30 am, 11:30 am, and 4:30 pm, with sliding scale Novolog insulin three times a day before meals (Novolog insulin is a rapid acting insulin used to treat elevated blood sugar in the blood).

Observation on 4/05/16 at 12:08 pm of the first shift Medication Aide (MA) for 100/200 Hall medication carts revealed:
-The MA rolled the 100 Hall medication cart down

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the hall to outside Resident #8's room.
-The MA donned vinyl gloves.
-The MA obtained a black zipper pouch labeled with Resident #8's name from the medication cart.
-Observation of the pouch revealed the pouch contained a Brand A glucometer (labeled with Resident #8's name), and a container of test strips. (The center of the pouch had a storage bracket for a lancing pen but no pen was in the pouch.)
-The MA inserted a new test strip into the glucometer.
-The MA obtained a lancing pen from the top of the medication cart, removed the clear plastic cap, inserted a new lancet from the top drawer, replaced the plastic end cap on the lancing pen, obtained an alcohol swab, and proceeded to Resident #8's room.
-The MA use the lancing pen to prick Resident #8's right index finger.
-A drop of blood was placed on the test strip and FSBS value of 211 was obtained.
-The MA returned to the medication cart where she removed the cap to the lancing pen, removed the lancet, and disposed of the test strip and lancet in the biohazard container.
-The MA recapped the lancing pen and wiped the pen with a fresh alcohol wipe, and placed the pen in the top left drawer of the medication cart. (The lancing pen was not labeled with a resident's name.)

Interview on 4/05/16 at 12:17 pm with the first shift MA for 100/200 Hall medication carts revealed:
-She had been a MA at the facility for over 2 years.
-The MA working first shift routinely administered medications and treatments for both the 100 Hall

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and 200 Hall.
-She worked first shift routinely but had filled in on different shifts and different medication carts.
-All residents had an assigned glucometer and she never shared glucometers.
-She had received training on glucometer infection prevention less than a week ago.
-The facility usually had single use disposable lancing devices that were used to obtain FSBS but they had run out about 2 weeks ago.
-She had used one of the 3 lancing pens to do Resident #8's finger stick.
-The routine she used was to clean the lancing pen by wiping with alcohol wipe before she started using the pen; then remove the pen cap, place a new lancet in the pen, twist off the needle cover, replace the plastic pen cap, obtain the finger stick, remove the pen cap, dispose of the lancet in the biohazard container, recap the pen, wipe with a fresh alcohol wipe, and return the lancing pen to the drawer.
-She had used the lancing pen since the facility ran out of single use disposable lancing devices.
-The MA stated she had informed the Resident Care Coordinator (RCC)and the Resident Care Director (RCD) that she was out of single use disposable lancing devices a "couple of weeks ago."

Based on observation of glucometers on the 100 Hall, 200 Hall, 300 Hall, 400 Hall, and 500 Hall and interview with the RCD on 4/05/16 at 1:30 pm, the facility had 23 residents receiving FSBS testing with none of the residents having a diagnosis of blood borne infectious disease.

Observation of the 100 Hall medication cart at 12:15 pm revealed:
-The upper left drawer contained a supply of loose lancets and multiple individual foil wrapped

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alcohol swabs, with 3 lancing pens laying on top of the lancets.
-The lancing pens were not labeled with a resident's name.
-The second drawer of the cart had 7 glucometer pouches, labeled with a resident's name, stored in the drawer.
-Each pouch contained a glucometer labeled with the corresponding resident's name.
-None of the 7 glucometer pouches contained a reusable lancing pen.
-There were no single use disposable lancing devices available for use on the 100 Hall medication cart.

Observation of the 500 Hall medication cart at 12:40 pm revealed:
-The upper left drawer contained a supply of loose lancets and multiple individual foil wrapped alcohol swabs, with 2 lancing pens laying on top of the lancets.
-The lancing pens were not labeled with a resident's name.
-The second drawer of the cart had 7 glucometer pouches, labeled with a resident's name, stored in the drawer.
-Each pouch contained a glucometer labeled with the corresponding resident's name.
-Six of the 7 glucometer pouches did not contain a reusable lancing pen.
-One of the 7 glucometer pouches contained a reusable lancing pen, however the resident no longer was ordered FSBS checks.
-There were no single use disposable lancing devices available for use on the 500 Hall medication cart.

Observation of the 200 Hall medication cart at 1:00 pm revealed:
-The upper left drawer contained a supply of

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loose lancets and multiple individual foil wrapped alcohol swabs, with 2 lancing pens laying on top of the lancets.
-The lancing pens were not labeled with a resident's name.
-The second drawer of the cart had 4 glucometer pouches, labeled with a resident's name, stored in the drawer.
-Each pouch contained a glucometer labeled with the corresponding resident's name.
-None of the 4 glucometer pouches contained a reusable lancing pen.
-There were no single use disposable lancing devices available for use on the 200 Hall medication cart.

Interview on 4/05/16 at 12:45 pm with the first shift MA for 500 Hall medication cart revealed:
-She had worked as a medication aide at the facility for more than 3 years.
-She routinely worked on the 500 Hall medication cart on first shift (7:00 am to 3:00 pm).
-The facility routinely had single use disposable lancing devices that MAs used to do finger sticks.
-The facility had placed an order more than 2 weeks ago.
-She had personally spoken to the medical supply representative on 3/24/16 to inform the supplier that the facility was out of single use disposable lancing devices.
-She was aware the facility was out of the single use disposable lancing devices currently (Tuesday 4/05/16), but stated the 500 Hall cart had a few on Saturday or Sunday 4/02/16 or 4/03/16).
-She used the lancet for the lancing pen, but not the pen, and twisted the safety end off the lancet to manually pricked the residents' fingers.
-She stated "I do not use anybody's pen to check somebody else (blood sugar) because might

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D932	Continued From page 29 have a disease". Observation of the 300 Hall medication cart, located in the Special Care Unit, at 1:25 pm revealed: -The upper left drawer contained a supply of loose lancets and multiple individual foil wrapped alcohol swabs, with one lancing pen laying on top of the lancets. -The lancing pen was not labeled with a resident's name. -The third drawer of the cart had 6 glucometer pouches, labeled with a resident's name. -Each pouch contained a glucometer labeled with the corresponding resident's name. -None of the 6 glucometer pouches contained a reusable lancing pen. -There were no single use disposable lancing devices available for use on the 300 Hall medication cart. Observation of the 400 Hall medication cart, located in the Special Care Unit, at 1:25 pm revealed: -The upper left drawer contained a supply of loose lancets and multiple individual foil wrapped alcohol swabs, with no lancing pen on the cart. -The third drawer of the cart had 1 glucometer pouch, labeled with a resident's name, stored in the drawer. -The pouch contained a glucometer labeled with the corresponding resident's name. -The glucometer pouch did not contain a reusable lancing pen. -There were no single use disposable lancing devices available for use on the 400 Hall medication cart. Interview on 4/05/16 at 1:25 pm with a first shift MA for the 300/400 Hall medication carts	D932		

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D932	Continued From page 30 revealed: -She had been a Medication Aide in the facility for 3 years. -She routinely worked first shift on Monday through Friday and every other weekend. -She performed finger sticks for diabetic residents on the 300 and 400 Halls. -She had obtained a finger stick on a resident from the 300 Hall medication cart and a resident from the 400 Hall cart at lunch today (4/05/16). -The facility routinely had single use disposable lancing devices to be used by staff for obtaining finger sticks but did not currently have the single use disposable lancing devices available for MA staff. -The facility had been out of the single use disposable lancing devices for more than one week. -There was only one lancing pen for use with the 300 Hall and 400 Hall medication carts. -The MA had used the lancing pen on the 300 Hall to obtain finger sticks for residents with glucometers on the 300 and 400 Halls. -She stated the RCC and Special Care Unit Director (SCUD) were aware the 300 and 400 Hall medication carts did not have single use disposable lancing devices. -The SCUD had instructed the MA that she could use the lancing pen until the single use disposable lancing devices were available. -The MAs requested diabetic testing strips, alcohol swabs, and single use disposable lancing devices from the SCUD. -She had received training on glucometer infection prevention in 2015. -She was aware the lancing pens were not supposed to be used for more than one resident but she did not have another method for obtaining finger sticks for residents. -The procedure she used for finger sticks was as	D932		

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D932	Continued From page 31 follows: each time she took the lancing pen apart, inserted a new lancet, replaced the cap, placed the pen on the resident's finger, activated the lancing pen, removed the pen cap, disposed of the lancet in the sharps container, and wiped the entire outside of the lancing pen with a fresh alcohol wipe. Interview on 4/05/16 at 2:05 pm with the RCC and RCD revealed: -They had been in their current positions for one month (3/04/16 was the starting date). -The facility policy was to use single use disposable lancing devices for residents' finger sticks. -They had both moved from the Special Care Unit to their current positions. -The RCD stated she was unaware the facility had lancing pens in the facility for staff to be able to use. -The RCD stated she had stocked the medication carts for glucometer test strips the day before (Monday) because MA staff had indicated they were low on glucometer test strips. -The RCD stated she did not look for the single use disposable lancing devices on the cart because she expected MA staff to inform her if they ran out. -The RCC and RCD stated no MAs had informed them they were out of the single use disposable lancing devices. -The RCD produced an unopened box of single use disposable lancing devices and stated the devices had been in a drawer in her office for more than a week. Interview on 4/05/16 at 2:10 pm with the SCUD revealed: -She had been in her current position for about 4 weeks.	D932		

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D932	Continued From page 32 -She was not aware the medication carts for 300 Hall and 400 Hall (Special Care Unit halls) did not have single use disposable lancing devices. -The diabetic supplies were currently ordered in the Assisted Living Unit of the facility. -Medication Aides would be responsible to let her know if they were out of single use disposable lancing devices. -She was aware a lancing pen should be assigned to one resident only and could not be shared. Interview on 4/05/16 at 3:54 pm with a second shift MA in the Assisted Living Unit revealed: -She had not used a reusable lancing pen to check finger sticks. -She used the lancet without the lancing pen to prick a resident finger if she did not have the single use disposable lancing devices. -The facility policy was to not use a lancing pen for anyone other than the resident to which it was assigned. Interview on 4/05/16 at 3:58 pm with another second shift MA in the Assisted Living Unit revealed: -She routinely worked on all the medication carts. -The facility had been out of single use disposable lancing devices for 7 to 10 days. -She had seen the reusable lancing pens on the medication carts but she had not used them. She used the lancets without the pen to prick the residents' fingers. Interview on 4/05/16 at 4:08 pm with a diabetic resident on the 100 Hall revealed: -He had MAs use the lancing pen, the little lancing device, and had MAs stick his finger with the pen lancet without the lancing pen. -He prefered the plain lancet with no device	D932		

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because it hurt the least.

Interview on 4/05/16 at 4:20 pm with a diabetic resident on the 200 Hall revealed:
-She got her finger stick check once a day.
-Staff had used the little lancing device (single use disposable lancing device) , and the pen lancet without the lancing pen.
-Some MA staff use the lancing pen (with the lancet).

Interview on 4/05/16 at 4:22 pm with a diabetic resident on the 500 Hall revealed:
-MA staff had used the lancing pen, the little lancing device, and stuck her finger with the pin-like lancet without the lancing pen within the last 2 weeks.

Interview on 4/07/16 at 9:30 am with the Administrator revealed:
-The RCD, RCC, or SCUD would be responsible to oversee the MAs for proper infection prevention for diabetic finger sticks.
-The single use disposable lancing devices were in the facility but had not been distributed to the medication carts by the RCD or RCC.

Interview on 4/07/15 at 9:50 am with the Corporate Nurse revealed:
-The facility policy was not to share glucometers, or lancing pens between residents.
-The MA staff had been trained on the required state infection prevention training course because she had taught the course.

Telephone interview on 4/07/16 at 5:00 pm with the facility's Consultant Pharmacist revealed:
-The contract pharmacy did not provide the diabetic supplies for the facility.
-She was not aware the facility had lancing pens

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D932	Continued From page 34 available for MA staff to use. -When the pharmacy Quarterly Review was done, she did not recall seeing lancing pens on the medication carts, however she did not specifically look for the pens. -The pharmacy recommendation would be to not have lancing pens available for staff to use. Review of the facility's "Infection Control Protocol" revealed documentation for "All diabetic supplies such as reusable lancing devices and glucometers are used for single residents." According to recommendation from the Centers for Disease Control and Prevention (CDC), fingerstick devices should never be used for more than one person. On 4/05/16, the facility provided a Plan of Protection as follows: -Prior to the next medication pass, the Resident Care Management has completed the following steps: Reviewed all medication carts and removed all but the single use lancing devices; restocked all medication carts with existing inventory of single use disposable lancing devices; reviewed infection control procedures related to diabetic blood glucose management with Medication Aides. -Medication carts will be routinely audited to ensure that single use lancing devices are the only ones in place for use by Medication Aides. -Review all incoming lancing devices at time of admission and/or receipt of equipment. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 08, 2016.	D932		