Division o	of Health Service Regu	ılation			FORIVIAPPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL045115	B. WING		R 04/07/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHERRY SPRINGS VILLAGE		R CREEK ROA SONVILLE, NC			
(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 APPROPR DEFICIENCY)	BE COMPLETE
{D 000}	Initial Comments		{D 000}		
	conducted a follow-up investigation on April investigation was initi	sure Section and the epartment of Social Services p survey and a complaint 6-7, 2016. The complaint iated by the Henderson of Social Services on March			
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care ar adequate, appropriate	elaration of Residents' Rights ration of Residents' Rights nave the following rights: nd services which are e, and in compliance with state laws and rules and	D912		
	reviews, the facility fa received care and sel appropriate, and in co	ns, interviews, and record ailed to ensure residents rvices which were adequate, ompliance with relevant s and rules and regulations			
	Based on interviews a facility failed to assure B and C), who were h Medication Aides (MA) the state written medical days after successful skills validation portion evaluation. [Refer to the facility of the state of the state written and the state written and the state of the s	A), had successfully passed ication examination within 60 completion of the clinical			

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					2	
HAL045115		B. WING		1	7/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CHERRY	SPRINGS VILLAGE		R CREEK ROA			
	OLUMBA DV OT		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
D912	Continued From page	e 1	D912			
	Competency (Unabat	ed Type B Violation).]				
D916	G.S. 131D-21(6) Dec	laration of Resident's Rights	D916			
	G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 6. To have his or her personal and medical records kept confidential and not disclosed without the written consent of the individual or guardian, which consent shall specify to whom the disclosure may be made, except as required by applicable state or federal statute or regulation or by third party contract. It is not the intent of this section to prohibit access to medical records by the treating physician except when the individual objects in writing. Records may also be disclosed with the written consent of the individual to agencies, institutions or individuals which are providing emergency medical services to the individual. Disclosure of information shall be limited to that which is necessary to meet the emergency. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain 51 of 51 resident records and personal information in a confidential manner.					
	The findings are:					
	The findings are: Observation of the main entrance area on 4/6/16 at 8:00pm revealed: -In the hallway, just beyond the front desk along the left wall, was a rolling metal rack that contained resident recordsEach resident record had a name label on the spine of the binder containing the recordThere was no staff in the Administrative offices near the records.					

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STATE FORM 6899 1PEJ12 If continuation sheet 2 of 9

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			7. BOILBING.		R	
		HAL045115	B. WING		1	7/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ΓΕ, ZIP CODE		
CHERRY	SPRINGS VILLAGE	358 CLEA	AR CREEK ROA	o .		
OHERICI V	TINGO VILLAGE	HENDER	SONVILLE, NC	28792	Т	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D916	Continued From page	2	D916			
	hallway in the vicinity -A housekeeper was the vicinity of the main -Residents were obse resident records in the Observation of the ma at 11:30am revealed: -The metal rack conta remained unmovedNo Administrative sta the recordsNo staff was present Observation of the ma at 4:00pm revealed: -The metal rack conta remained unmovedA staff member was	of the dining room. at her housekeeping cart in an entrance. erved moving past the enallway. ain entrance area on 4/6/16 aining the resident records aff were in the offices near				
	at 5:45am revealed: -The metal rack contaremained unmoved.	ain entrance area on 4/7/16 aining the resident records aff were in the offices near at the front desk.				
	4/7/16 at 5:55am reve -The resident records "all the time." -The offices were lock -The medication aide	were kept in the hallway				

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out of the facility.

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	or Beelowale		0/2:	CONCERNATION	0.00 = :== =	
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		CONFLETED		
A. E				R		
		HAL045115	B. WING	B. WING		/2016
			1		, 0.,017	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CHEDDY	SPRINGS VILLAGE	358 CLE	AR CREEK ROA	D		
CHERRY	OF KINGS VILLAGE	HENDER	SONVILLE, NC	28792		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(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 APPROPF DEFICIENCY)	RIATE	DATE
				,		
D916	Continued From page	e 3	D916			
	Observation of the ma	ain entrance area on 4/7/16				
	at 6:30am revealed:	an chirance area on 4/1/10				
		aining the resident records				
	remained unmoved	aming the resident resords				
		in a wheelchair and two				
		, were in vicinity of the front				
	entrance.	,				
	-No staff was present	at the front desk.				
	Interview with the Administrator on 4/7/16 at					
	7:00am revealed:					
	-Resident records had	d been placed in the hallway				
		nd locked in the RCC's office				
	"at night."					
	-The MA had access	to the records at night but				
	the records were ever	ntually moved into the				
	hallway.					
	-Resident records nee	eded to be out on third shift				
	for medication aide ad	ccess if residents were				
	transferred.					
		re placed in the hallway				
	when staff were know	n to be around them.				
	A	the the a A charical atoms (
		ith the Administrator on				
	4/7/16 at 11:00am rev					
		of a policy or procedure for				
	maintaining resident r					
	•	in a confidential manner or				
	location.	too away from public access				
		-She would find an area away from public access to safely keep the resident records.				
	to salely keep the res	nucin records.				
(D005)	0.0004045.4.55%	101114 F - C - 411	(D005)			
{D935}		ACH Medication Aides;	{D935}			
	Training and Compete	ency				
	0.0.04045.4.55.4.5	Adult Open Ham				
	G.S. § 131D-4.5B (b)					
		nining and Competency				
	Evaluation Requireme	ents.	1			

Division of Health Service Regulation

STATE FORM 6899 1PEJ12 If continuation sheet 4 of 9

	or periornoise		(VO) MULTIPLE	CONCTRUCTION	(V2) DATE CUI	DVEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDIEAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMILETED	
		HAL045115	B. WING		R 04/07 /	/2016
		1.0.2.0.0.0.0	1		, 0	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CHEDDY	SPRINGS VILLAGE	358 CLEA	R CREEK ROA	D		
CHERRI	SPRINGS VILLAGE	HENDERS	ONVILLE, NC	28792		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
			1	DEFICIENCY)		
{D935}	Continued From page	Δ Δ	{D935}			
(====)	Continued From page	•	(
		r 1, 2013, an adult care				
	home is prohibited fro	m allowing staff to perform				
	any unsupervised me	dication aide duties unless				
	that individual has pre	eviously worked as a				
	medication aide durin	g the previous 24 months in				
	an adult care home of	r successfully completed all				
	of the following:					
	(1) A five-hour training	g program developed by the				
	Department that inclu	des training and instruction				
	in all of the following:					
	a. The key principles	of medication				
	administration.					
	b. The federal Center	s for Disease Control and				
	Prevention guidelines	on infection control and, if				
	applicable, safe inject					
		oring or testing in which				
		e potential for bleeding				
	exists.	, , , , , , , , , , , ,				
		aluation consistent with 10A				
	` '	10A NCAC 13G .0503.				
		m the date of hire, the				
		completed the following:				
	a. An additional 10-ho	· · · · · · · · · · · · · · · · · · ·				
	developed by the Dep					
		n in all of the following:				
	The key principles					
	administration.					
		s of Disease Control and				
		on infection control and, if				
	applicable, safe inject					
		oring or testing in which				
		e potential for bleeding				
	exists.	S potential for biceuing				
		veloped and administered				
		alth Service Regulation in				
	accordance with Subs	section (c) of this section.				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL045115	B. WING		R 04/07/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CHERRY	SPRINGS VILLAGE		R CREEK ROA		
			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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D935}	Continued From page	2 5	{D935}		
	This Rule is not met FOLLOW-UP TO A T				
	Based on these findin Violation was not aba	igs, the previous Type B ted.			
	Based on interviews and record reviews, the facility failed to assure 2 of 3 sampled Staff (Staff B and C), who were hired after 10/1/13 as Medication Aides (MA), had successfully passed the state written medication examination within 60 days after successful completion of the clinical skills validation portion of a competency evaluation.				
	The findings are:				
	record revealed: -She was hired on 12 (MA)Documentation Staff medication administra -Documentation Staff were validated on 12/ -There was no docum successfully complete medication examinati successfully complete skills validation. Review of Staff B's tir March 2016 revealed	nentation Staff B had			
		6 electronic Medication ds (eMARS) for 2 randomly			

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STATE FORM 6899 1PEJ12 If continuation sheet 6 of 9

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						_
					F	₹
		HAL045115	B. WING		04/0	7/2016
NAME OF D		CTDEET AD	DRESS, CITY, STA	ATE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	,		
CHERRY	SPRINGS VILLAGE		R CREEK ROA			
		HENDERS	SONVILLE, NC	28792		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
{D935}	Continued From page	2.6	{D935}			
(2000)	Continued From page	. 0	(2000)			
	observed residents de	uring a medication pass on				
	4/6/16 at 8:30am reve	ealed documentation of				
	medications administ	ered by Staff B.				
		•				
	Review of Staff B's tir	ne punches for the month of				
	April 2016 revealed:	•				
	•	a 2nd shift MA on 4/1 and				
	4/2.					
		a 3rd shift MA on 4/3 and				
	4/4.	a ora orint with ori 4/3 and				
	7/7.					
	Review of April 2016 electronic Medication					
	-					
		ds (eMARS) for 5 randomly				
		uring a medication pass on				
		vealed documentation of				
	medications administ	ered by Staff B.				
		call to Staff B on 4/7/16 was				
	not returned prior to e	exit.				
	Refer to interview with	h the Business Office				
	Manager on 4/7/16 at	: 10:30am.				
	· ·					
	Refer to interview with	h the Resident Care				
	Coordinator on 4/7/16	3 at 10:45am.				
	Refer to interview with	h the Administrator on 4/7/16				
	at 10:55am	in the frammed ator on the frame				
	at 10.00am.					
	B Paview of Staff C'	s personnel and training				
	record revealed:	s personner and training				
		12/16 as a Medication Aide				
		12/10 as a ivieuication Aide				
	(MA).	Chad received the 5 have				
		C had received the 5-hour				
		ation training on 1/28/16.				
		C's medication clinical skills				
	were validated on 1/2					
	-There was no docum	nentation Staff C had				
	successfully complete	ed the state written				
		on within 60 days after				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL045115	B. WING		R 04/07/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
CHERRY	SPRINGS VILLAGE	358 CLEA	R CREEK ROA	D		
HENDERS			SONVILLE, NC	28792		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
{D935}	Continued From page	e 7	{D935}			
	successfully completi skills validation.	ng the medication clinical				
	2016 through April 6,	me punches for March 29, 2016 revealed she had on 3/31, 4/1, 2, 3 and 5.				
	Review of March 2016 electronic Medication Administration Records (eMARS) for 2 randomly observed residents during a medication pass revealed documentation of medications administered by Staff C.					
	Review of April 2016 electronic Medication Administration Records (eMARS) for 5 randomly observed residents during a medication pass revealed documentation of medications administered by Staff C.					
	Interview with the Business Office Manager on 4/7/16 at 10:30am revealed: -She, the Administrator and the Resident Care Coordinator were responsible for ensuring the MA met all of the requirements prior to passing medicationsShe was aware the MA had to successfully complete the state written medication examination within 60 days of successfully completing the medication clinical skills validationShe was uncertain of the date Staff B would be taking the state written examinationStaff C was taking the state written examination that day (4/7/16). Interview with the Resident Care Coordinator on 4/7/16 at 10:45am revealed: -She, the Administrator and the Business Office Manager were responsible for ensuring the MA met all of the requirements prior to passing					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _				
HAL045115		B. WING		04/0	7/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CHERRY SPRINGS VILLAGE			CREEK ROA			
	T		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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D935}	Continued From page	: 8	{D935}			
	medicationsShe was uncertain as medications if her me validation had been conshe had not taken the examStaff C was taking the examination that day. Interview with the Adr 10:55am revealed: -She was unaware the medications if she had the medication clinical successfully completed medication examinations. Staff B was scheduled medication examinations. Staff B would not be after she had success written medication examination that day. A Plan of Protection wand included the follonstaff B was removed. Medication AideShe would not be allowed the staff of the work of the	s to why Staff B was passing dication clinical skills ompleted on 12/30/15 and state written medication e state written medication (4/7/16). ministrator on 4/7/16 at e MA could not pass discussfully completed I skills validation but had not ed the state written on within 60 days. Ed to take the state written on in June 2016. passing medications until sfully completed the state amination on 5/3/16. e state written medications (4/7/16). was provided by the facility wing: from the schedule as a bowed to pass medication test, the Medication Aide training				

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