STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted an annual and follow-up survey on February 15, 2018.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures at the sinks in three common bathrooms used by all residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F. The findings are: Observation during the initial tour of the facility on 2/15/18 from 8:50am to 8:57am revealed: -The facility had a total of five residents and three common bathrooms. -At 8:50am the hot water temperature coming from the sink in the second common bathroom on the right side of the hall was 122 degrees F. -At 8:55am the hot water temperature coming from the sink in the only common bathroom on	C 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 105	Continued From page 1	C 105		

the left side of the hall was 122 degrees F.
-At 8:57am the hot water temperature coming from the sink in the first common bathroom on the right side of the hall was 130 degrees F.

On 2/15/18 at 9:05am the Supervisor-in-Charge (SIC) was informed of the hot water temperatures and hot water cautions signs were posted on the bathroom doors to inform residents about the hot water.

Interviews on 2/15/18 at 10:07am and 10:25am with the Relief Supervisor-in-Charge (RSIC) revealed:
-He performed maintenance duties.
-The water temperatures were checked every morning by the SIC or the RSIC.
-Water temperature readings were recorded on a log.
-He had turned up the water temperature on 2/13/18 when he was cleaning and waxing the floors "the hot water helps to get the wax up".
-He did not remember to turn the water temperature back down.
-"I just now turned the water temperature back down to 116 (degrees F)."
-"Another reason the water temperature is up is because in our room at the back of the house the water is luke warm."

Observations on 2/15/18 at 10:32am and 10:34am of a recheck of the water temperature from the first common bathroom on the right side of the hall revealed:
-The RSIC used a meat thermometer to check the temperature.
-He always used a meat thermometer to check the water temperatures.
-The water temperature coming from the sink was 110 degrees F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 105	Continued From page 2 -The water temperature using the surveyor's thermometer was 112 degrees F. Observation on 2/15/18 at 1:00pm of a recheck of the water temperature from the last common bathroom on the right hand side of the hallway revealed a temperature of 106 degrees F. Review on 2/15/18 at 11:00am of a weekly water temperature log revealed: -The year of 2017 was handwritten on the top of the log. -The dates were from 7/10/17-9/11/17. -No other logs were provided by the facility. Interview on 2/15/18 at 10:45am with the Administrator revealed: -The SIC was responsible for checking the water temperatures weekly. -The water temperatures had been adjusted one month earlier. -The RSIC or the SIC were to record the readings on a log. -"I have monitored. I should monitor more." -"They know the ruling." -The SIC monitors the water temperatures. Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures at 3 of 3 common bathroom sinks used by 5 of 5 residents were maintained between 100-116 degrees F. A water temperature of 130 degrees F can result in a third degree burn in 30 seconds. The facility's failure to ensure water temperatures were between 100-116 degrees F put all residents at risk of burns and was detrimental to safety, health, and welfare of the residents and constitutes a Type B Violation.	C 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 105	Continued From page 3 The facility provided a Plan of Protection on 2/15/18 that included: -Hot water caution signs were posted to ensure all residents were aware of hot water temperatures. -Water temperatures were adjusted immediately to ensure compliance with rules and regulations. -Staff will monitor for the next three days until water temperatures are remaining in a consistent range. -Staff will check twice a day for the next three days. -Staff will monitor weekly to ensure water temperatures are in the range of 100-116 degrees F. -Staff will notify the Administrator immediately if water temperatures need to be adjusted accordingly to meet the rule and regulation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 1, 2018.	C 105		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 202	Continued From page 4 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#1) was tested for tuberculosis (TB) disease in compliance with TB control measures utilizing the 2-step testing method. The findings are: Review of Resident #1's current FL2 dated 5/30/17 revealed: -Diagnoses that included hypertension, intracerebral hemorrhage, degenerative joint disease, gastritis, delerium tremors, chronic pain syndrome, schizophrenia, and diabetes. -There was a readmission date of 3/18/16. Review on 2/15/18 of Resident #1's medical record revealed: -There was documentation of a Step 2 TB skin test on 2/19/14 which read as negative on 2/21/14. -There was no other documentation of TB skin tests. -There was a Resident Register dated 3/18/16. Interview on 2/15/18 at 11:40am with the Supervisor-in-Charge (SIC) revealed: -The facility Nurse Practioner would give the TB tests to the residents. -The facility would take residents to the health department for TB tests. -The residents would have the first step TB skin test before they were admitted to the facility. -The date of the first step TB skin test would be written on the admission FL2. -The SIC or the Administrator was responsible for monitoring the TB tests.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 202	Continued From page 5 Interview on 2/15/18 at 1:05pm with the Administrator revealed: -The residents must have the first step TB skin test before admission. -"We follow up with a second step in one month with the on site physician." -"The staff monitors and lets me know if one is needed." -The Administrator was sure Resident #1 had another TB skin test. No further TB skin testing was provided by the end of the survey.	C 202		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter. This Rule is not met as evidenced by: Based on interviews and record review, the facility fail to assure a medical examination was completed annually and the results entered on the FL2 (North Carolina Medicaid Program Long Term Care Services) as required for 1 of 3 sampled resident (Resident #3). The findings are: Review of Resident #3's current FL2 dated 11/15/16 revealed diagnoses of major neurocognitive disorder, schizophrenia and	C 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 203	Continued From page 6 alcohol use disorder. Review of Resident #3's record revealed: -Resident #3 was admitted to the facility on 11/4/16. -The most current FL2 was dated 11/15/16. -There was a signed Physician's Orders form dated 10/30/17. -There was a completed yet unsigned FL2. Interview on 2/15/18 at 9:40am with the Supervisor-in-Charge (SIC) revealed: -She was aware Resident #3's FL2 was out of date. -It was her responsibility to assure the FL2 got signed by the physician. -"It's my fault the FL2 is not signed". -She "did not know" how the oversight had happened. -When she learned of the oversight, she completed a new FL2 and gave a copy to the administrator to obtain the physician's signature. Interview on 2/15/18 at 12:30pm with the administrator revealed: -She was aware the FL2 for Resident #3 was out of date. -She thought she had gotten a new FL2 completed by Resident #3's Primary Care Physician (PCP) when she was at the facility on 2/5/18. -She "attempted to" get a new FL2 signed every 6 months. -The SIC was responsible to provide her with a completed FL2 when it was time to obtain the signature from the PCP. -Resident #3's FL2 not being signed "was an oversight" on her part. -She would fax the FL2 to the PCP today.	C 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 231	Continued From page 7	C 231		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure a functional assessment (Care Plan) was completed annually for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 11/15/16 revealed: -Diagnoses of major neurocognitive disorder, schizophrenia and alcohol use disorder.	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 231	Continued From page 8 -The resident was oriented, ambulatory and continent of bowel and bladder. Review of a Resident Register for Resident #3 revealed an admission date of 11/4/16. Review of Resident #3's record revealed: -The most current completed Personal Care Physician Authorization and Care Plan was signed by Resident #3's Primary Care Physician (PCP) on 12/27/16. -Resident #3 was documented requiring limited assistance with eating, no other personal care needs were indicated. Attempted interviews on 2/15/18 at 9:04am and 9:16am with Resident #3 revealed: -He had been at the facility for about "one and one-half to two years". -He chose not to participate in any further interview questions. Interview on 2/15/18 at 9:40am with the Supervisor-in-Charge (SIC) revealed: -She was aware Resident #3's Care Plan was out of date. -It was her responsibility to assure the Care Plan got signed by the physician. -"It's my fault the Care Plan is not signed". -She "did not know" how the oversight had happened. -When she learned of the oversight, she completed a new Care Plan and gave a copy to the administrator to obtain the physician's signature. Interview on 2/15/18 at 12:30pm with the administrator revealed: -She was aware the Care Plan for Resident #3 was out of date.	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 231	Continued From page 9 -She thought she had gotten a new Care Plan completed by Resident #3's Primary Care Physician (PCP) when she was at the facility on 2/5/18. -She "attempted to" get a new Care Plan signed every 6 months. -The SIC was responsible to provide her with a completed Care Plan when it was time to obtain the signature from the PCP. -Resident #3's Care Plan not being signed "was an oversight" on her part.	C 231		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to offer or make available foods and beverages that are appropriate to residents' diets to 5 of 5 residents between each meal for a total of three snacks per day and shown on the menu as snacks. The findings are: Interviews on 2/15/18 from 8:50am to 9:07am during the initial tour with three residents revealed: -One resident stated "sometimes" they got a snack.	C 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 272	Continued From page 10 -Snacks were not always available. -"We don't have any snacks." -The Supervisor-in-Charge (SIC) "doesn't offer any snacks". -Snacks "were not offered much". -One resident had recently asked for a snack and was given one. Observations on 2/15/18 from 8:45am through 1:15pm in the facility revealed no snacks were offered or made available to the residents. Observation on 2/15/18 at 10:45am in the kitchen revealed: -There was a Fall Cycle, Week 2, No Concentrated Sweets Menu on the counter to the left of the refrigerator, with 3 ounces of grape juice and ¾ ounce pretzels listed as the Thursday (2/15) snack. -There was a separate Snack Menu posted on a cabinet door above the counter to the right of the stove. Interview on 2/15/18 at 10:50am with the Supervisor-In-Charge (SIC) revealed: -She was "supposed to do [snacks] three times a day". -If a resident asked for a snack she would "give them something". -For snacks, she followed the Fall Cycle, Week 2, No Concentrated Sweets Menu and not the Snack menu. -Currently she had "no snacks" on hand to offer the residents. -She ran out of snacks "over the weekend and the last of the peanut butter yesterday". -The Owner/Licensee purchased the snacks for the facility and "was bringing food today". Observations on 2/15/18 at 11:00am of snacks	C 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 272	Continued From page 11 items available in the facility revealed: -One, 12 ounce can of frozen concentrated juice in the freezer. -One, 16 ounce box of saltine crackers. -Two apples and approximately 10 ounces of trail mix in the dining room. Interview on 2/15/18 at 11:15am with the Administrator revealed: -The Owner/Licensee purchased the snacks for the facility per what is listed on the menu. -Staff are to "offer snacks to the residents three times per day, at 10:00am, 3:00pm and at bedtime". -She did not know the reason there were no snack items in the facility. Interview on 2/15/18 at 11:25am with the Owner/Licensee revealed: -He purchased the snacks for the facility per what is listed on the menu on a weekly basis. -He just delivered snacks to the facility. -Staff "had not made him aware" that the facility had run out of snacks over the weekend. -He purchased snacks for the facility on either Thursday's or Friday's.	C 272		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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, interviews and record	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011341	A. BUILDING: _____ B. WING _____	R 02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE FAMILY CARE HOME # 3	8 ELLA LANE ALEXANDER, NC 28701

(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
C 912	Continued From page 12 reviews, the facility failed to assure each resident received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to hot water temperatures. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures at the sinks in three common bathrooms used by all residents were maintained between 100 degrees Fahrenheit (F) and 116 degrees F.[Refer to tag C105, Rule 10A NCAC 13G .0317(d) Building Service Equipment (Type B Violation)].	C 912		