Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
		HAL044022	B. WING		10/2	3/2018
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 10/2	10/10
			NUT PARK DRI			
CHESTNU	IT PARK RETIREMENT	WAYNESVI	LLE, NC 2878	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	0 Initial Comments		D 000			
		sure Section conducted an survey on October 23, 2018.				
D 139	10A NCAC 13F .0407 Qualifications	(a)(7) Other Staff	D 139			
	(a) Each staff person (7) have a criminal ba	Other Staff Qualifications at an adult care home shall: ockground check in 114-19.10 and 131D-40;				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	facility failed to ensure	ews and interviews, the e 1 of 3 sampled staff (Staff kground check completed				
	The findings are:					
	revealed: -Staff A had been and multiple times since 0 -Staff A's last date of SupervisorThere was criminal be completed on 02/24/0	hire was on 08/23/18 as a ackground check 14. documentation of a criminal				
	revealed: -She had been emplosince 2000." -In her current positio primarily responsible	on 10/23/18 at 2:50pm yed at the facility "off and on n as Supervisor, she was for administering sting the residents with				

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

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7445 1 2744 0	or contraction	IDEITH IOMION NOMBER.	A. BUILDING: _		OOMI ELTED
		HAL044022	B. WING		10/23/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CHESTNU	T PARK RETIREMENT		NUT PARK DRI ILLE, NC 2878		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 139	-She had asked the A completed a criminal rehire on 08/22/18 and her she had not. Interview with the Adr 3:20pm revealed: -She had not complet check on Staff A where 08/22/18"We had to get her in somebody reliable to residents." The facility failed to a background check confacility's failure results unaware of any crimin which was detrimentate of the residents and of the residents and of the residents and of the residents." The facility provided a accordance with G.S. this violation.	ne facility on 08/22/18. dministrator if she had background check upon id the Administrator had told ministrator on 10/23/18 at red a criminal background in she was rehired on a quickly, so we had take care of these sure Staff A had a criminal mpleted upon hire. The red in the facility being hal background history, all to the safety and welfare constitutes a Type B	D 139		
D 283	7, 2018. 10A NCAC 13F .0904 Service	4(a)(2) Nutrition and Food	D 283		
		Nutrition and Food Service nt and Safety in Adult Care			

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 2 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		HAL044022	B. WING		10	0/23/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CHESTNU	IT PARK RETIREMENT		STNUT PARK DRIV	Ē		
	T		SVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 283	prepared or served b protected from contain This Rule is not met Based on observation reviews, the facility fabeverages being stor protected from contain The findings are: Review of the facility dated 12/14/17 reveated 12/14/17	rage being procured, stored, y the facility shall be mination. as evidenced by: n, interviews, and record alled to ensure food and ed by the facility were mination. kitchen sanitation report alled: yed for date marking and as, an opened package of hed potatoes in a cooler we been date marked during efrigerator at the back of the at 10:35am revealed: astic bowl covered with a appeared to be slaw ted. canister covered with a snap d what appeared to be apple	D 283			
	snap on lid which cor macaroni and cheese -There was a large pl dressing label on the	not dated. c bowl covered with a clear ntained what appeared to be e unlabeled and not dated. fastic jug with a ranch outside one third full which ared to be pickle relish				

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 3 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		
	HAL044022	B. WING		10/23/2018	;
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
CHECTAILLE DA DIZ DETIDEMENT	84 CHES	TNUT PARK DRIV	E		
CHESTNUT PARK RETIREMENT	WAYNES	SVILLE, NC 28786			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMP HE APPROPRIATE DAT	PLETE
which contained what bacon grease unlabed -There was a second mayonnaise label on amount of purple subthandwritten label on -There was loose delin the bottom of the results of the kitchen on 10/2 - There was a 2 pounwith a sell by date of -There was a gallon scontained peeled cutton-There was one gallot labeled "apples" date -There was one gallot labeled "apples" date -There was a whole if storage bag would be a contained peeled cuttoners was a whole if storage bag would be a contained cate of the was a quart scontained and the contained cuttoners had freezer -There were three gas which contained cuttoners was a contained cuttoners. There were two gallot which contained red not dated. -There were seven guitanters was a second contained cuttoners was a contained cuttoners.	lastic canister with a the outside one eighth full t appeared to be leftover eled and not dated. I large plastic canister with a the outside with a small estance in the bottom with a the lid "jelly" and no date. oris and multiple spills visible efrigerator. Treezer, located at the back 23/18 at 10:49am revealed: d package of brussel sprouts 06/08/14. Sized clear plastic bag which up apples dated 11/13/15. In sized clear plastic bag ad November 2016. Inch wide by two inch thick reezer burn stored in a clear with no label and no date. Tish frozen in an ice block tic storage bag with no label ize clear plastic bag with a rnips" with no date, and the	D 283			

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 4 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL044022	B. WING		10/2	3/2018
NAME OF PROVIDE	ER OR SUPPLIER	STREET ADD	RESS, CITY, STA		1	<u></u>
CHESTNUT PAR	RK RETIREMENT		NUT PARK DRI LLE, NC 2878			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 283 Con	Continued From page 4		D 283			
stora - The what unla - The of ba - The corn - The com - The zucc Obs kitch - The of w date - The unla - The u	age area on 10/23 ere was a gallon s at appeared to be a beled and not dat ere was half full ga acon unlabeled ar ere was a gallon s a dogs unlabeled a ere were eleven la amercially package ere were two gallo chini squash piece ervation of the ref anen on 10/23/18 a ere was a clear pla that appeared to b ere was a gallon of the ere was a ga	allon sized clear plastic bag and not dated. ized clear plastic bag with and not dated. irge sized bags of ed soup undated. In sized plastic bags with es unlabeled and not dated. irigerator located in the at 11:03am revealed: estic bowl with a snap-on lid e chili unlabeled and not container of orange juice ed. Ir gallon containers of ges unlabeled and not dated. ized bag of cheese slices ed. In the state of the second				

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 5 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL044022	B. WING		10/23/2018
					10/23/2010
NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
CHESTNUT PARK RETIREMENT			INUT PARK DRI		
			VILLE, NC 2878		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 283	Continued From page 5		D 283		
	11:37am revealed: -The left over food wand dated when store-Any left over food wout within three days Telephone interview 10/23/18 at 1:45pm re-The old food was ge-The new food was ge-The new food was ge-The refrigerators and quarterly for labeling, -All staff who worked food were responsible	as supposed to be labeled ed. as supposed to be thrown if not used. with the Administrator on			
D 298	D 298 10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult 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 reviews, the facility failed to offer or make available three snacks a day to all residents and shown on the menu. The findings are:		D 298		
D 298	-The new food was g -"We will have to pull away." -The refrigerators and quarterly for labeling, -All staff who worked food were responsibl areas clean and for p food items. 10A NCAC 13F .0904 (d) Food Requirement (2) Foods and beveratesidents' diets shall to all residents as snate a total of three snack menu as snacks. This Rule is not met Based on observation reviews, the facility fa available three snack shown on the menu.	etting used before the old. the old food and throw it d freezers were checked dating, and cleanliness. in the kitchen preparing e for keeping food storage proper labeling and dating of 4(d)(2) Nutrition And Food 4 Nutrition And Food Service hts in Adult Care Homes: ages that are appropriate to be offered or made available acks between each meal for s per day and shown on the as evidenced by: ns, interviews, and record ailed to offer or make	D 298		

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 6 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
]		
		HAL044022	B. WING		10/23/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		84 CHESTI	NUT PARK DR	IVF	
CHESTNUT PARK RETIREMENT			ILLE, NC 2878		
			T 2070		
(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
D 298	298 Continued From page 6		D 298		
	-				
	-Five of five residents	were not offered a snack			
	three times a day.	stated analys were not			
		stated snacks were not			
	made available to the -None of the five resid	· · · · · · · · · · · · · · · · · · ·			
	hungry between meal				
		ered snacks "sometimes."			
		as offered snacks "once in			
	the afternoon."	as shered shacks sheem			
		offered snack "about two			
	times a week."				
	-A fourth resident "us "after supper."	ually" was offered a snack			
	-A fifth resident stated snack before bedtime	d he had to ask staff for a			
	-Examples of snack for	oods resident's had received			
	in the past included p potato chips, and can	opcorn, packs of crackers, dy bars.			
	Deview of the feeting	the area and the manner for			
	Review of the facility 10/23/18 revealed the snacks.	therapeutic menu for e menu listed three daily			
	-	pervisor on 10/23/18 at			
	11:37am revealed:				
	_	's come and ask us when			
	they want snacks."				
	-"We don't have a set	snack time."			
	Observations on 10/2	3/18 from 9:15am to			
		snacks were offered or			
	made available to res				

Division of Health Service Regulation

Observations on 10/23/18 at 1:30pm of the snack

STATE FORM 9899 Y32611 If continuation sheet 7 of 12

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL044022	B. WING		10/23/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CHESTNU	T PARK RETIREMENT		TNUT PARK DRI VILLE, NC 2878		
040.15	SHWWWDV ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORREC	TION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
D 298	Continued From page 7		D 298		
ח א א א א א א א א א א א א א א א א א א א	food available in the frevealed: -There were 16 boxes contained four 1/2 cup-There was one open crackers with two undinside (16 sheets of g sheets equal to one servings which contained appless and the fire were six packers pudding which contained by the fire were four 8 oz chips which contained available in the frevealed: -There were four 8 oz chips which contained by the fire were three care contained six servings. -There was a half full chips which contained by the fire was a neathing puffs which contained by the fire were six indiviting from the fire were six indiviting from the fire were four packets. -There were four packets with six servings per contained. -There were two boxes servings per contained. Observations on 10/2	sof raspberry jello which p servings per box. box of cinnamon graham opened packs of crackers iraham crackers with 2 serving. unce (oz) jars of auce. ages of butterscotch ned four 1/2 cup servings 23/18 at 2:00pm of the snack facility medication room 2 bags of regular potato deight 1 oz. servings. nisters of potato chips which is per canister. 140 gram bag of barbeque dethree 50 gram servings per defull 15 oz bag of cheese in 15 servings per bag. dually wrapped fruit and skages of cheese crackers package. 2 box of crackers with 36 ser. 2 sof saltine crackers with 30 ser. 23/18 from 1:05pm to snacks were offered or made	D 290		
		ok on 10/23/18 at 1:20pm			

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 8 of 12

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMI	PLETED
	HAL044022 B. WIN		B. WING		10)/23/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
CHECTAIL	T DADIZ DETIDEMENT	84 CHES	STNUT PARK DRIV	/E		
CHESINU	IT PARK RETIREMENT	WAYNES	SVILLE, NC 28786	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 298	98 Continued From page 8		D 298			
	snacks for residents i -"I have not been doin -She did not have sna kitchen storage to ser -"I didn't know snack day." -"I thought it was twice afternoon." Telephone interview v 10/23/18 at 1:45pm re -The Supervisor or th serving snacks.	ng a morning snack." ack foods enough in the rve to residents for snacks. was required three times a e a day in the morning and with the Administrator on evealed: e Cook were responsible for at night when we give out				
D912	G.S. 131D-21 Declar Every resident shall head to receive care and adequate, appropriate relevant federal and stregulations. This Rule is not met Based on interviews a facility failed to assurant services which we have to shall be a service of the service of the shall be a service of the service of the shall be a shall	e, and in compliance with state laws and rules and as evidenced by: and record reviews, the e residents received care ere adequate, appropriate th federal and state laws and	D912			

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 9 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 BOILBING		
		HAL044022	B. WING		10/23/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CHESTNU	CHESTNUT PARK RETIREMENT 84 CHES				
		WAYNESV	ILLE, NC 2878	6	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D912	2 Continued From page 9		D912		
	facility failed to ensure A) had a criminal back prior to hire. [Refer to	ews and interviews, the e 1 of 3 sampled staff (Staff kground check completed Tag 0139 10A NCAC 13F ff Qualifications (Type B			
	Violation)].	ii Qualifications (Type D			
D992	G.S.§ 131D-45 (a) Ex	amination and screening	D992		
	G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.				
	(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency,				

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 10 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL044022	B. WING		10	0/23/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
CHESTNU	JT PARK RETIREMENT		'NUT PARK DRIV /ILLE, NC 28786	E		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D992	prescribed. If the result employee's examinating the presence of a concare home may require	which the substance is all of an applicant's or some screening indicates strolled substance, the adult are a second examination by the results of the prior	D992			
	facility failed to ensure screening for the pres	and record reviews, the e examination and sence of controlled ormed for 1 of 3 sampled				
	revealed: -Staff A had been and multiple times since 0 -Staff A's last date of SupervisorThere was a signed in the personnel recordThere were no other in the recordThere was no docum completed. Interview with Staff A revealed: -She had been emplosince 2000."	consent for a drug screening rd dated 05/31/12. consents for drug screening mentation a drug screen was on 10/23/18 at 2:50pm				
	primarily responsible	n as Supervisor, she was for administering sting the residents with				

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 11 of 12

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL044022	B. WING		10)/23/2018
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
CHESTNU	IT PARK RETIREMENT	WAYNES	SVILLE, NC 28786	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D992	personal careShe was rehired at the She had not complet rehire on 08/22/18. Interview with the Adra 3:20pm revealed: -The Administrator was drug screens were conbefore hire.	ne facility on 08/22/18. ed a drug screen upon ministrator on 10/23/18 at as responsible for ensuring impleted on applicant's ed a drug screen on Staff A d on 08/22/18. in quickly, so we had	D992			

Division of Health Service Regulation

STATE FORM 9899 Y32611 If continuation sheet 12 of 12