STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021008	A. BUILDING: _____ B. WING _____	R-C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON PRIME TIME RETIREMENT VILLAGE	105 MARK DRIVE EDENTON, NC 27932

(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 conducted a follow-up survey with an onsite visit on 03/09/21 and 03/10/21 and a desk review survey on 03/11/21 and a telephone exit on 03/11/21.	{D 000}		
{D 079}	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of obstructions and hazards as evidenced by free-standing, unsecured oxygen tanks being stored in the hallway, janitor closet, and one resident room on the assisted living side of the facility; and a sharps container and toiletry liquids and creams not being stored securely, an unlocked and unsecured shower room being used for storage with boxes and a broken mirror, and a large bottle of hand sanitizer being stored in the open day room all accessible to residents in the Special Care Unit. The findings are: 1. Observations on the initial tour of the facility on 03/09/21 at 10:45am revealed: -There were two oxygen tanks, standing upright and unsecured on the floor in the hallway, outside of resident room #139.	{D 079}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meredith Sears For Kathy Capehart, Administrator | TITLE: COO | (X6) DATE: 4/20/2021

Reviewed & Accepted
05/10/21 Wela Y. Wynn

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{D 079}	Continued From page 1 -There was no crate in view for the tanks to be stored. -This hallway was located on the assisted living (AL) side of the facility with many occupied resident rooms and residents who were frequently traveling the hallway with canes, walkers and wheelchairs. -One resident used the siderails in the hallway to propel herself in her wheelchair down the hallways. -Another resident was receiving physical therapy services and used the siderails to support herself. -There were two more oxygen tanks standing upright and unsecured in resident room #139 on the floor. -It was unknown if any of the oxygen tanks observed were empty or full. -There were two attempts to interview the resident in room #139 who used the oxygen, but she was deeply asleep and unable to be interviewed. Interview with the Administrator on 03/09/21 at 12:15pm revealed: -She was unaware that there were free-standing and unsecured oxygen tanks in the hallway of the AL. -She did not have a process in place to safely store oxygen tanks. -She usually stored the empty and full oxygen tanks in the free-standing, upright and unsecured position as observed in the resident's room on the floor until they called the durable medical equipment (DME) provider, who supplied the oxygen, to come and exchange them. -Other than a small metal cart with wheels that contained and stored the one oxygen tank that was in use by the resident, there was no oxygen tank holder or crate in the resident's room to safely store the oxygen tanks and prevent tipping.	{D 079}	Administrator secured all housekeeping chemicals in the housekeeping room and lotions in the med room. SIC and Housekeeping have a key to the door. Administrator will obtain approved storage crates for oxygen. Oxygen tanks will be stored in approved storage crates. Broken mirror in spa room and picture has been discarded. Spa room not in use will remain locked. Administrator/Designee will walk through building weekly x 6 weeks to ensure all items are stored properly and anything needing to be repaired are reported as outlined in facility procedures. Anything needing attention will be added to the maintenance log book as outlined in facility procedures. Maintenance Director will check maintenance log book and make necessary repairs timely.	3/12/2021 3/12/2021-3/18/2021 3/12/2021 - 3/19/2021 3/19/2021 & Ongoing

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{D 079}	Continued From page 2 -She was asked by the survey team to remove the oxygen tanks from the resident's room and secure the oxygen tanks in a safe manner to prevent tipping. Observation of the janitor closet with the personal care aide (PCA)/MA/supervisor on 03/10/21 at 12:18pm revealed: -The janitor closet was unlocked because the door was not able to be locked. -There were 7 full oxygen tanks standing upright on the floor and unsecured, just below a fire extinguisher mounted on the wall, and next to a furniture dolly, industrial mop bucket, and a trash can. Interview with a PCA/medication aide (MA)/ supervisor on 03/10/21 at 11:50am revealed: -The resident in room #139 was the only resident in the facility who used oxygen. -Staff were to store empty and full portable oxygen tanks in the locked janitor closet: except for the tank that was in use, which was stored in a metal cart with wheels next to the resident. -Some of the oxygen tanks in the janitor closet were unsecured and she was unsure which tanks were empty or full of oxygen. -She was unsure of who's responsibility it was to make sure the oxygen tanks were secured and stored safely. -The facility did not have a rack or cart to secure any of the oxygen tanks that were not in use. -The supervisor in charge, maintenance staff and the Administrator had a key to the janitor closet where the full and empty oxygen tanks were to be stored. Telephone interview with the facility contracted DME provider on 03/10/21 at 4:25pm and 03/11/21 at 10:14am revealed:	{D 079}		

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{D 079}	Continued From page 3 -The DME provider only provided an oxygen tank holder with wheels for the resident receiving oxygen. -The holder was to be used by the resident to transport the oxygen tank in use around with the resident. -They did not normally provide storage containers, racks, or shelves to store oxygen tanks, and expected the facility to purchase their own. -The facility called the morning of 03/11/21 to request a storage rack or crate to store the oxygen tanks that were not in use. -The DME provider agreed to provide the facility with a cardboard storage container that was sturdy and could be used long-term or replaced upon request free of charge. -The DME provider expected the facility to store unused tanks laying down or on a rack or crate, that prevented them from tipping, in a closet with a door and out of the way of residents and staff. -It was not recommended to leave any oxygen tanks standing upright and unsecured in open areas, hallways or around residents because they were potentially combustible, as well as a fall hazard to residents. 2. Observation of the Special Care Unit (SCU) medication room door and the office door on 03/03/21 at 11:00am revealed: -The medication room door was locked -The office door was unlocked and open. -There was access to the medication room through the adjoining bathroom. -The personal care aide was in the day room across the hall with six of the SCU residents. Observation of the SCU spa shower room on the right side of the hall on 03/09/21 at 11:05am revealed:	{D 079}		

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{D 079}	Continued From page 4 -The door was unlocked. -There was a sharps container with a few items in it on the top of the half wall of the shower. -There was a 16 ounce (oz) plastic bottle of moisturizing lotion that did not have a cap on it on top of the half wall of the shower. -There was a 25.4oz plastic bottle of shampoo on top of the half wall of the shower. -The caution label on the bottle of shampoo had to avoid contact with eyes. -There was a 16oz plastic bottle tar gel shampoo on top of the half wall of the shower. -The warning label had to avoid contact with the eyes. If contact occurs, rinse eyes thoroughly with water. -There was another 25.4 oz plastic bottle of shampoo on top of the half wall of the shower. -The caution label on the bottle of shampoo had to avoid contact with eyes. -There was an empty aerosol can of air freshener on the top of the half wall of the shower. -The warning label had harmful to skin and eyes. -There was a 11.5oz plastic bottle of body wash on the top of the half wall of the shower. Observation of the SCU spa room on the left side of the hall on 03/09/21 at 11:20am revealed: -The spa room door was unlocked. -There was a large framed picture with glass front leaned up against the wall behind the door. -There was a long mirror that was broken at the bottom leaned up against the wall across from the door. -There was one resident walking in the hall. Observation of a resident's room #131 in the SCU on 03/06/21at 11:25 revealed: -There was a basket of toiletry items behind the door. -There was a 22oz plastic bottle of body wash in	{D 079}		

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{D 079}	Continued From page 5 the basket that was half full. -There was a 24 oz plastic bottle of body wash in the basket that was ¾ empty and had a warning label that had keep out of reach of children, for external use only, and avoid contact with eyes. -There was a 13.5oz plastic bottle of shampoo that was almost full. -There was a 12oz plastic bottle of conditioner that was almost full. -There was a 12 oz plastic bottle of anti-dandruff shampoo that was half full. -The warning label had avoid contact with eyes. -There was a 7.5oz plastic bottle of soap that was ¾ full. -There was a 5.07oz plastic round container of cream. -There was a 13.5oz plastic bottle of conditioner that was almost full. -There was a 33oz plastic bottle of shampoo. -There was a caution label that had for external use only and to avoid getting in eyes. -There was an 8oz plastic tube of lotion. -The warning label had for external use only and to avoid contact with eyes. -There was another 8oz plastic tube of lotion. - The warning label had for external use only and to avoid contact with eyes. -There was an unopened 8.4oz closet odor eliminator. -The warning label had keep out of reach of children. Not for internal consumption. Interview with a medication aide /supervisor (MA/S) at 03/09/21 at 11:05 revealed: -There were three residents in the SCU that wander in other residents' room. -The residents' toiletry items were to be kept in the medication room with the door locked. -She had not given any showers this morning. -She was not aware the toiletry items and the	{D 079}		

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{D 079}	Continued From page 6 sharps container were in the spa bathroom. -It was each staff member working their shifts in the SCU responsibility to make sure the toiletry items were put away. -She did not know of any resident ever ingesting any toiletry items. Interview with the Administrator on 03/09/01 at 12:14pm revealed: -The toiletry items were to be kept locked up when not in use in the SCU. -It was the responsibility of the personal care aides (PCA) working in the SCU to make sure the items were locked up when not in use. -It was her responsibility to make sure the PCAs were locking the toiletry items up when not in use in the SCU. -The last time she was in the SCU was 03/08/21 but she did not look at the toiletries. -The time before that was on Thursday 03/04/21 but she did not check to see if the toiletry items were locked up. -The residents in the SCU walk around in the halls but none of the residents were wanderers. -No resident has ever tried to ingest any of the toiletry items. -The other spa bathroom was to be locked at all times due to it being used as a storage room. Interview with a PCA on 03/10/21 at 9:35am revealed: -The toiletry items were to be kept locked in the medication room in the SCU. -The PCA working in the SCU was responsible for making sure the toiletries were locked in the medication room in the SCU.	{D 079}		