

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2021
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NAME OF PROVIDER OR SUPPLIER BECKY'S REST HOME # 2	STREET ADDRESS, CITY, STATE, ZIP CODE 316 LOWER BRUSH CREEK ROAD FLETCHER, NC 28732
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(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 an annual survey and complaint investigation on 12/15/21 through 12/16/21. The complaint investigation was initiated by the Buncombe County Department of Social Services on 12/02/21.	D 000	The staff referred to in this complaint investigation is no longer employed or living at the facility.	1/7/22
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews it was determined that the facility failed to ensure resident rights were maintained as related to residents freedom to use the common dayroom without two staff members sleeping on the sofa and recliner chair.</p> <p>The findings are:</p> <p>Interview with a resident on 12/15/2021 at 9:58am revealed: -Two staff members had slept on the couch and a recliner chair in the facility dayroom. -She thought the staff members had slept in the dayroom between three and four weeks. -They had stopped sleeping in the dayroom about two weeks ago.</p> <p>Second interview with the resident on 12/16/2021 at 4:40pm revealed: -The two staff members would go in and out of the dayroom at various times throughout the day</p>	D 338	<p>Staff training has been completed by Pharmacy Nurse Consultant on Resident Rights on January 7, 2022. Administrator will conduct resident interviews monthly to monitor compliance with Resident Rights. A copy of the Adult Care Home Resident Rights is posted in the facility.</p>	

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator (X6) DATE 1/26/2022
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D 338	<p>Continued From page 1</p> <p>and evening.</p> <ul style="list-style-type: none"> -She sometimes watched the news, game shows, and church services in the dayroom but stopped when the staff members were in there. -She was uncomfortable being in the dayroom when they were in there. -She felt the staff members were intruding on the residents' space. -She had not mentioned to staff or the Administrator she was uncomfortable with the staff members in the dayroom. -She was unsure why she did not mention it to the Administrator. <p>Interview on 12/16/21 at 11:51am with the Administrator revealed:</p> <ul style="list-style-type: none"> -The two staff who had been sleeping in the dayroom at night were waiting on a room in building #1 to be repaired. -The two staff were working for the facility in the kitchen. -The two staff had recently became homeless and with the cold weather she was not going to let them sleep outside. -She was always in the facility and had never been approached by any residents that they had concerns about the two staff sleeping in the dayroom at night. <p>Interview on 12/16/21 at 12:26pm with a Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> -She worked from 7:00am to 7:00pm as a PCA. -She was aware that the two staff who worked in the kitchen had slept in the dayroom for 3 nights. -During the hours she worked she had not seen them sleeping or "hanging around" in the dayroom. -They worked in the kitchen and did not complete the kitchen work until after she had left the facility at night. 	D 338		

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D 338	<p>Continued From page 2</p> <p>Interview on 12/16/21 at 1:00pm with the cook in the kitchen revealed: -He and his son had recently started working at the facility in the kitchen. -They slept for 3 nights in the dayroom and then they were able to move into a room in building #1. -They never wanted to make anyone feel uncomfortable and tried to wait as late as possible to go into the dayroom. -No one approached them about sleeping in the dayroom. -They started in the kitchen at around 6:00am and would not finish until around 7:30pm.</p> <hr/> <p>The facility failed to ensure the residents rights to freely use the dayroom without feeling uncomfortable because two staff members slept in the dayroom preventing residents from having access to the television and common dayroom. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.</p> <hr/> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/16/21 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 30, 2022.</p>	D 338		
D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration,</p>	D911		

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D911	<p>Continued From page 3</p> <p>dignity, and full recognition of his or her individuality and right to privacy.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with respect, consideration, dignity, and full recognition of his or her right to privacy.</p> <p>The findings are:</p> <p>Based on interviews it was determined that the facility failed to ensure resident rights were maintained as related to residents freedom to use the common dayroom without two staff members sleeping on the sofa and recliner chair. [Refer to tag 338, 10A NCAC 13F .0909 Type B Violation].</p>	D911		