STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092199	A. BUILDING: _____ B. WING _____	06/24/2021

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BRIGHT HORIZON	1405 FALLS CHURCH ROAD RALEIGH, NC 27609

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 24, 2021.	C 000		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home 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 homes. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain a hazard-free environment related to four unsecured oxygen cylinders in a resident room. The findings are: Observation of a semi-private resident room on 06/24/21 at 8:48am revealed: -There were four unsecured oxygen (O2) cylinders that were 25.5 inches in length sitting upright on the floor. -There was no rack or crate positioned at the foot of a hospital bed. -There was an O2 cylinder in a portable stand and oxygen concentrator stored on the floor at the foot of a hospital bed. Interview with a personal care aide (PCA) on 06/24/21 at 8:40am revealed:	C 078		

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C 078	Continued From page 1	C 078		

-The resident received services from hospice.
-The resident had O2 ordered and delivered recently at the end of May 2021 because the resident's condition had changed one day.
-She was not working the day the O2 cylinder was delivered.
-The oxygen was delivered by hospice services.

Interview with a medication aide (MA) on 06/24/21 at 3:45pm revealed:
-She was told hospice delivered oxygen for one of the residents who resided in the semi-private room in May 2021.
-When the O2 cylinder was delivered, she was not working.
-She had not seen an O2 cylinder storage rack within the facility or the semi-private room.
-She had not reported the unsecured O2 cylinder to other staff or management of the facility.
-She had not reported there was not a storage rack for the O2 cylinders to other staff or management of the facility.
-She had not contacted the hospice provider for an O2 cylinder storage rack since it was delivered on May 2021.

Interview with the Supervisor-in-Charge (SIC) on 06/24/21 at 4:24pm revealed:
-She knew five O2 cylinders were delivered to the facility in May 2021 for the resident assigned to the semi-private resident room.
-She did not check to make sure the O2 was secured in a rack or crate after it was delivered.
-She was aware O2 cylinders were unsecured in the semi-private resident room.
-She thought O2 cylinders could be stored in a closet.
-She did not contact the resident's hospice services, and she had not requested a rack or crate to place the unsecured O2 cylinders into for

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C 078	Continued From page 2 storage. -She thought a rack or crate to store the O2 cylinders was supposed to be delivered with the O2 cylinders. -She was concerned that the O2 cylinders were unsecured and at risk of being bumped. -She expected staff to place the O2 cylinders into a closet for storage. Telephone interview with the Administrator on 06/24/21 at 4:48pm revealed: -She knew the resident had recently received O2 cylinders to administer O2. -She expected staff to contact hospice services to determine if the resident needed five O2 cylinders. -She thought O2 cylinders always needed to be kept away from hazards. -She did not know there were four unsecured O2 cylinders in the facility. -She was responsible for ensuring oxygen cylinders were stored securely in a rack or crate. Based on observations, interviews, and record review, it was determined the resident assigned to the semi-private resident room was not interviewable.	C 078		
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	C 105		

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C 105	Continued From page 3 F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 3 of 4 fixtures at two sinks and one shower in two residents' bathrooms. The findings are: Review of the facility's bathroom water temperature log revealed: -There were columns for the date, an unidentified faucet, the kitchen faucet, hallway bathroom faucet, the semi-private bathroom faucet, and staff initials. -There were temperatures documented for the hallway bathroom the Administrator as follows: dated 01/25/21 for 111 degrees F, 02/02/21 for 113 degrees F, 03/21/21 for 112 degrees F, 04/04/21 for 113 degrees F, 05/05/21 for 111 degrees F, 05/06/21 for 112 degrees F, and 05/27/21 for 111 degrees F. -There were temperatures documented for the semi-private bathroom the Administrator as follows: dated 01/25/21 for 114 degrees F, 02/02/21 for 113 degrees F, 03/21/21 for 112 degrees F, 04/04/21 for 112 degrees F, 05/05/21 for 112 degrees F, 05/06/21 for 113 degrees F, and 05/27/21 for 111 degrees F. -There were temperatures documented for the hallway bathroom by the Supervisor-in-Charge (SIC) as follows: dated 01/21/21 for 112 degrees F, 06/13/21 for 111 degrees F, and 06/21/21 for 112 degrees F. -There were temperatures documented for the semi-private bathroom by the SIC as follows:	C 105		

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C 105	Continued From page 4 dated 01/21/21 for 113 degrees F, 06/13/21 for "11" degrees F, and 06/21/21 for "11" degrees F. Observation of water temperature in the hallway resident bathroom on 06/24/21 at 8:51am revealed the bathroom sink fixture water temperature was 114.1 degrees F and the bathtub/shower fixture water temperature was 127.3 degrees F. Observation of a water temperatures in the semi-private resident bathroom on 06/24/21 at 8:54 am revealed a sink fixture water temperature was 126.3 degrees F. Observation of the facility on 06/24/21 at 9:24am revealed: -There was a thermometer available for staff to use. -The Supervisor-in-Charge (SIC) used a small meat thermometer to test the water temperature. -The SIC obtained a water temperature at the hallway bathroom sink fixture of 120 degrees F utilizing the small meat thermometer. Observation of the sink fixture in the hallway bathroom on 06/24/21 at 9:24 am revealed a water temperature was 129.2 degrees F. Interview with a personal care aide (PCA) on 06/24/21 at 3:12pm revealed: -She had worked for the facility for six years and never took the water temperatures. -The Administrator took the water temperatures for the facility when she visited the facility. -She bathed the residents using the hallway bathroom because it was larger than the semi-private bathroom. -She had not noticed any problems with the water temperatures, and she asked the residents prior	C 105		

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C 105	Continued From page 5	C 105		

to bathing if the water temperature was comfortable.

Interview with a medication aide (MA) on 06/24/21 at 3:45pm revealed:
-She did not take water temperatures for the facility.
-The Administrator took the water temperatures.
-She assisted all five residents with bathing and used the hallway bathroom to bathe residents.
-She had not noticed any steam coming from the hallway bathroom fixtures.

Interview with the Supervisor-in-Charge (SIC) on 06/24/21 at 9:24am revealed:
-The water temperatures were checked weekly by the Administrator or a designee.
-She had not noticed the water temperatures were so high.
-She thought the water temperatures were supposed to range between 104 degrees F to 105 degrees F.
-When the water temperatures were too high, she reported it to the Administrator.
-She told the Administrator the water temperature obtained at 9:24am of 129.2 degrees F.

Telephone interview with the Administrator on 06/24/20 at 4:48pm revealed:
-She thought the water temperature range for the facility was not supposed to exceed 110 degrees F.
-The water temperature was checked every other week.
-She kept the water temperature logs in a binder.
-She was informed by the SIC that the water temperatures were high.
-She thought the thermometer used by the facility was not calibrated properly and needed to be replaced.

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C 105	Continued From page 6 -She did not know the water temperature in the hallway bathroom and semi-private bathroom were too high. -She was not in state and planned to have the water temperature adjusted upon her return on 06/29/21. -She was responsible for ensuring the water temperature was maintained between 100 degrees F and 116 degrees F. Observation of the water temperatures in the hallway resident bathroom on 06/24/21 at 4:09pm revealed the bathroom sink fixture water temperature was 129.0 degrees F and the bathtub/shower fixture water temperature was 129.6 degrees F. Observation of a water temperature in the semi-private resident bathroom on 06/24/21 at 4:12pm revealed a sink fixture water temperature was 127.4 degrees F.	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		

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C 202	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #1's current FL-2 dated 04/27/21 revealed diagnoses included dementia, musculoskeletal deformity, type 2 diabetes mellitus, hypertension, and chronic kidney disease. Review or Resident #1's Resident Register revealed there was an admission date of 05/21/20. Review of Resident #1's record for a tuberculosis (TB) skin test revealed: -There was documentation of a tuberculosis (TB) skin test given on 05/15/20 and read as negative on 05/17/20. Interview with the medication aide (MA) on 06/24/21 at 4:05pm revealed the Administrator usually arranged and scheduled the second TB test. Interview with the Supervisor-in-Charge (SIC) on 06/24/21 at 4:24pm revealed: -She was not able to locate another TB skin test for Resident #1 in the record. -The Administrator usually arranged the second TB skin test for residents admitted to the facility. Telephone interview with the Administrator on	C 202		

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C 202	Continued From page 8 06/24/21 at 4:48pm revealed: -Residents were admitted with a completed TB skin test and then another TB skin test was completed after admission. -If a second TB skin test was not done then a gold interferon test was completed. -She placed the TB skin test under the admission, healthcare, or lab section of the resident's record. -She did not know if Resident #1's had a second TB skin test or not. -She did not know that the first and second TB skin tests could be no more than one year apart. -She was responsible for ensuring residents had a completed second TB skin test. Based on observations, record reviews, and interviews, it was determined Resident #1 was not interviewable.	C 202		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to have matching therapeutic diet menus for food service guidance 1 of 3 sampled residents (#3) with physician order for a regular mechanical soft diet (#3). The findings are:	C 270		

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C 270	Continued From page 9 Review of the facility menu revealed: -The menu was posted on the refrigerator in the kitchen. -The menu was a spreadsheet that indicated a regular diet menu, low fat/low cholesterol diet menu, and diabetic diet menu for week 1 Thursday. -The menu was signed by a registered dietician and the dietician's number was beside her name. -There were food selections for breakfast, lunch, dinner, and 3 snacks. -The lunch meal for Thursday was a hamburger on whole wheat bun, lettuce/tomato, 1 teaspoon mustard and/or ketchup, ½ cup baked French fries, ½ cup green beans, ½ cup applesauce, 1 cup iced tea, and 1 cup water. -The lunch meal for Thursday was hamburger sliders, baked beans, baked French fries, sliced cake, iced tea and water. Review of Resident #3's current FL-2 dated 05/25/21 revealed: -Diagnoses included Huntington's Chorea (primary), dysphagia, and migraine. -There was a diet order for a regular mechanical soft diet and nectar thickened liquids. Observation of Resident #3's lunch meal service on 06/24/21 at 12:24pm revealed: -Resident #2 was served in the dining room. -Resident #2 had a bowl of chopped hamburger meat, a bowl of mashed potatoes, baked beans, square of yellow cake with vanilla icing, and nectar thickened tea. Interview with the Supervisor-in-Charge (SIC) on 06/24/21 at 9:59am revealed Resident #3 was on a mechanical soft diet.	C 270		

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C 270	Continued From page 10 Observation of the facility on 06/24/21 at 11:12am revealed the personal care aide (PCA) was overheard asking if Resident #3 could eat a sandwich and the SIC responded no. Interview with the SIC on 06/24/21 at 11:22am revealed the facility did not have a mechanical soft diet. Interview with a Medication Aide (MA) on 06/24/21 at 11:38am revealed: -She had not seen a mechanical soft menu in the facility since working there for the past 3 years. -Resident #3 had an order for a mechanical soft diet and a food processor was used to chop up her food. -She had not received any training on the preparation of pureed or mechanical soft diets. -The Administrator described to staff what should be done to prepare foods for a mechanical soft diet. Interview with a PCA on 06/24/21 at 3:12pm revealed: -She had worked for the facility for 6 years and had not seen a mechanical soft menu in the facility to use. -Usually the Administrator provided a piece of paper listing the residents' food preferences, likes and dislikes. -The Administrator sent out a message to all staff when a resident was admitted communicating information specific to the resident such as the diet order. -She thought the Administrator sent a text message to all staff when Resident #3 was admitted, and the message included her diet order. -Resident #3 had a regular soft diet, and a food processor was used to soften her food.	C 270		

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C 270	Continued From page 11 -She had not received any training on preparing a soft or pureed diet, and she had learned over time how to prepare a soft diet. -She had not requested a mechanical soft menu from the SIC or the Administrator. -If she had questions about how to prepare a food item on the menu, she contacted the SIC. -She asked the SIC earlier if she could feed Resident #3 the bread or not. -She substituted the bread with mashed potatoes. Interview with the SIC on 06/24/21 at 4:24pm revealed: -The Administrator sent a group chat to all staff to communicate new information about residents such as diet orders. -More senior staff knew how to prepare a mechanical soft diet because they had done this type of job for a while. -She came in and assisted new staff with preparing meals and if they had any questions staff could call her. -She had a question about the lettuce and tomato listed on the menu for the lunch meal service. -She did not know that a mechanical soft menu would provide guidance for what to feed a resident with a mechanical soft diet for the lettuce and tomato. -She now understood why a therapeutic menu was needed to match the therapeutic diet. Telephone interview with the Administrator on 06/24/21 at 4:45pm revealed: -She did not have a mechanical soft menu for staff to utilize in the facility. -She knew Resident #3 had a diet order for a mechanical soft diet. -She sent out a group communication to staff to inform them of specific information about residents.	C 270		

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C 270	Continued From page 12 -She had a regular diet menu and thought the staff could chop up or provide soft foods to provide a mechanical soft diet. -There should be a piece of paper on the refrigerator with the resident food preferences. -She was responsible for ensuring there was a matching therapeutic menu for each physician-ordered therapeutic diet. Based on observations, record reviews, and interviews, Resident #3 was not interviewable.	C 270		
C 353	10A NCAC 13G .1006(b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents' medications was maintained in a safe manner under locked security. The findings are: Observation of a resident's bed side table on 06/24/21 at 1:30pm revealed: -There was a tube of Baza protective cream with a medication label. -There was a bottle of nystatin powder with a medication label. -The resident was not in the room.	C 353		

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C 353	Continued From page 13 Observation of the kitchen on 06/24/21 at 1:15pm revealed there were six bottles of Miralax on the kitchen counter with residents' initials written on the individual bottles. Interview with a Personal Care Aide/Medication Aide (PCA/MA) on 06/24/21 at 2:50pm revealed: -She knew medications should be kept under locked security. -The Baza cream and nystatin powder were left inside the resident's bedside table drawer, but it was prescribed by the primary care provider (PCP). -Since it was prescribed, the Baza cream should be locked in the medication closet. -Resident's Miralax was kept in the kitchen because it was easier to mix in the juice for the morning breakfast meal and administer to the residents. -The MAs should have locked the Miralax back in the medication closet. Interview with the MA on 06/24/21 at 3:45pm revealed: -All medications were supposed to be stored under lock and key or in a locked medication cabinet. -She identified creams and powders as medication and these medications were ordered by the PCP. -Creams and powders should be stored under lock and key. -She thought another staff forgot to place the resident's Baza cream and nystatin powder back into the medication closet. -Miralax was a medication and should be stored under lock and key and not stored in the kitchen. -She placed the Miralax in the kitchen and forgot to put it back into the medication closet.	C 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092199	A. BUILDING: _____ B. WING _____	06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHT HORIZON	1405 FALLS CHURCH ROAD RALEIGH, NC 27609

(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 353	Continued From page 14 Interview with the Supervisor in Charge (SIC) on 06/24/21 at 4:24pm revealed: -Medications were stored in a locked medication closet or a locked box in the refrigerator. -The resident's Baza cream and nystatin powder were inside the bedside table drawer and should have been locked in the medication closet. -The residents' Miralax bottles were left in the kitchen and should have been locked in the medication closet. Telephone interview with the Administrator on 06/24/21 at 4:45pm revealed: -She thought the creams and powders should be allowed to be left at the bedside for staff to use for bedbound residents. -She thought the creams and powders should be allowed to be left in the resident's bathrooms to use after toileting because staff could not leave the residents to retrieve these medications from the medication closet. -She expected staff to lock other medications in the locked medication closet. -She knew the staff were leaving residents' Miralax in the kitchen to use for residents in the morning time. -She had told staff to lock the residents' Miralax back in the medication closet. -Staff on duty were responsible for maintaining medications under locked security.	C 353		