STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 on 03/19/24.	{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, interviews, and record reviews, the facility failed to maintain an environment free of hazards including cleaning products, and personal care products that were accessible to the residents living in the special care unit (SCU). The findings are: Review of the facility's undated Environmental Safety Policy revealed: -Facility staff would ensure the safety of residents residing in the special care unit (SCU) with consideration of residents' rights and dignity. -The SCU would be assessed for items which could be misperceived by a resident as something to eat or drink and would be safely stored in an inaccessible location to residents. -Upon entering the SCU, it was daily practice for the Dementia Care Coordinator or designee to do a review of all residents' rooms and common areas for environmental safety. -Unsafe items would be removed.	{D 079}	On 3/19/24, an audit was conducted of all resident rooms in SCU to remove/ lock up all hazardous personal care items, cleaning products, disposable raxors, and potentially hazardous products. Items that could not be locked up were removed from the residents rooms and SCU. On 3/19/24, Care Services Director audited all current SCU resident's apartments to ensure that the environment is free of hazards including disposable razors, cleaning products, and personal care products, and that these items are stored in a locked location. Any hazardous items found were noted and locked up/stored appropriately. On 3/19/24, another education was started by care services director to all SCU care associates regarding rule area and protocol/process for ensuring the environment is free of hazards including disposable razors, cleaning products, and personal care products. In addition, an in-service was given on hos to stor these items in a locked location and how to access them. Administrator and/or designee will check each residents apartment to ensure that the environment is free of hazards, including disposable razors, cleaning products, and personal care products and that these items are stored in a locked location. The audits will be conducted by administrator and/or designee daily x 4 weeks, weekly x 1 month, and monthly x 3 months for safety. Ongoing random audits will also be conducted. Negative findings will be corrected, if noted. Completion date: 3/21/24	

Reviewed and Acknowlwdged 05/22/24

Nola J. Dixon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 079}	Continued From page 1 -Knives, scissors, tools, or other similar items should be stored where they are inaccessible to residents and monitored when in use. -Potentially hazardous personal items such as resident toiletries, nail polish, powders, deodorant, toothpaste, etc. shall be stored per physician's statement/order. -It was best practice to have all potentially hazardous items locked up in all resident rooms to ensure the safety of all residents in the SCU. Review of the facility's census report received on 03/19/24 revealed there were 75 residents living in the SCU of the facility. Observation of room A06 and A07 shared bathroom on A hall in the SCU on 03/19/24 at 9:31am revealed: -There were personal care items in a drawer included body spray, insect repellent oil, toothpaste, deodorant and first aid antibiotic ointment. -Warnings on the labels of some of the personal care products included: keep out of reach of children; for external use only; if swallowed get medical help or to contact the poison control center (PCC) or physician; avoid contact with eyes; in case of eye contact flush with water; and harmful if ingested. Interview with a family member on 03/19/24 at 9:32 revealed: -The bathroom sink cabinet doors had a lock but were not locked. -The bathroom cabinet doors were not locked during last week's visit. -Personal care items were kept in the top drawer. -She had not observed the resident misuse the personal care items.	{D 079}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 079}	Continued From page 2 Based on observations and interviews it was determined the residents residing in rooms A06 and A07 were not interviewable. Observation of room A09 bathroom on A hall in the SCU on 03/19/24 at 9:44am revealed: -There were personal care items placed on the on the counter of the cabinet which included various lotions, perfume, and hand soap. -The bathroom sink cabinet doors had a lock but was not locked. -The bathroom sink cabinet had items of fingernail polish remover, hair mousse and disinfectant wipes. -The warning label on the disinfectant wipes included hazardous to humans and domestic animals; causes moderate eye irritation; and call a PCC or physician for treatment advice. Interview with a family member on 03/19/24 at 9:44am revealed: -The personal care items had been brought in by a family member who kept some of the items on top of the sink area and under the sink cabinet. -The staff had not locked the cabinet sink because the resident knew how to properly use the items and would not ask staff to unlock the cabinet each time she needed the items. -The resident had not been known to consume the items. Based on observations and interviews it was determined the resident residing in rooms A09 was not interviewable. Observation of room B03 bathroom on B hall in the SCU on 03/19/24 at 9:47am revealed: -The bathroom sink cabinet was not locked. -There were personal hygiene items in the bathroom sink cabinet which included 2 bottles of	{D 079}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 079}	Continued From page 3 body wash and lotion. Observation of room D03 on the D hall in the SCU on 03/19/24 at 9:51am revealed: The bathroom sink cabinet was not locked. -There were personal hygiene items inside of the cabinet which included deordorant. Observation of room D09 on the D hall in the SCU on 03/19/24 at 10:03am revealed: -There were personal hygiene items of deodorant, toothpaste, hand sanitizer and body lotion. -The bathroom sink cabinet was not locked and there was personal hygiene itemswhich included deodorant, shaving cream, toothpaste, shampoo and 2 bars of soap inside of the cabinet. Observation of room C02 on the C hall in the SCU on 03/19/24 at 10:11am revealed: -The bathroom sink cabinet was not locked. -There were personal hygiene items of antibacterial soap, 3 bottles of body lotion, body cream, and 2 jars of petroleum jelly. Observation of room C09 on the C hall in the SCU on 03/19/24 at 10:15am revealed: -The bathroom sink cabinet was not locked. -There were personal hygiene items of body wash, toothpaste, hand soap and hand sanitizer placed under the sink cabinet. Interview the with a housekeeper on 03/19/24 at 12:53pm revealed: -The housekeeping staff did not have keys to unlock the residents' bathroom sink cabinets. -The PCAs were responsible for locking the bathroom sink cabinets. Interview with a personal care aide (PCA) on	{D 079}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 079}	Continued From page 4 03/19/24 at 10:19am revealed: -Residents personal care items were kept locked under the sink bathroom cabinet. -The cabinets that contained any personal care items were required to be kept locked. -There were some residents who were allowed to keep their personal care items unlocked because they were independent with some personal care like brushing their teeth and toileting. -Residents who were not independent with personal care could ingest items like lotion or misuse the mouthwash. -Residents were not allowed to have hand sanitizer or disinfectant wipes because the items were hazards. -He had known of any resident misusing their personal hygiene items. -He checked the residents' bathroom each shift to ensure the bathroom sink cabinets were locked and were locked after needing to use the hygiene items. Interview with a SCU medication aide (MA) on 03/19/24 at 10:24am revealed: -Only residents who had been assessed to be independent of some personal care and who had a locks on their room door could have direct access to their personal hygiene items. -Residents were not allowed to have hand sanitizer and disinfectant wipes because they could get confused on how the items were to be used. -The PCAs and MAs were responsible for ensuring the cabinets were locked and checked during each shift. Interview with a second SCU MA on 03/19/24 at 10:33am revealed: -Residents were not allowed to have disinfectant wipes.	{D 079}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 079}	Continued From page 5 -The PCAs were to place the personal hygiene items back inside of the cabinets and lock the cabinets. -There were some residents who were allowed to keep their toothpaste and toothbrush out on the counter because they were capable of brushing their teeth without supervision. -Residents were to report to staff if their bathroom sink cabinet locks were broken. -Residents knew their cabinets were to be locked. Interview with Memory Care Supervisor on 03/19/24 at 11:21am revealed: -Residents were not allowed to have disinfectant wipes or hand sanitizer in their rooms. -Some residents were allowed to have toothpaste, toothbrush, and an electric razor on the sink countertop. -Personal hygiene items like deodorants, shampoos, bodywash, soaps and lotions were to be locked. -The bathroom cabinets were to be checked at each shift to ensure the cabinets were locked and the cabinets were to be locked after each use of a resident hygiene items. -Some residents needed to have their personal care hygiene items locked because it was a safety issue because the residents may mistake the items for food. -Residents were not capable of informing staff when the cabinet locks were broken or not working properly. Interview with the Assisted Living Director on 03/19/24 at 11:54am revealed: -Hygiene items were to be locked under the bathroom cabinet sinks. -PCAs and MAs were to ensure the bathroom cabinets were locked. -MAs were to supervise the PCAs on that task to	{D 079}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 079}	Continued From page 6 make sure broken cabinet locks were reported to maintenance. -There were some SCU residents who were allowed to keep at least toothpaste and toothbrushes unlocked.	{D 079}		
{D 234}	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (Resident #3) was tested for Tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health utilizing the 2-step testing method. The findings are: Review of Resident #3's current FL-2 dated 02/13/24 revealed diagnosis of history of a closed fracture. Review of Resident #3's Resident Register revealed she was admitted to the facility on 10/30/23 from another residence.	{D 234}	On 3/20/24, Reisdent #3 was given a 2nd step TB test by care services director. The test will be read on 3/22/24. On 3/22/24, Administrator audited all current reisdents to ensure that all residents have 2 step TB tests completed. Any gaps/discrepencies were noted and TB tests were given, as appropriate. Administrator and/or designee will keep track of all new admissions to ensure TB tests are given within proper timing parameters. Any residents needing 2nd step TB will be discussed during weekly care team meeting on Thursdays. TB tests will be completed/read as appropriate. Completion Date: 3/22/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 234}	Continued From page 7 Review of Resident #3's record revealed: -There was documentation that a 1st step tuberculosis (TB) test was administered on 10/06/23 and read on 10/08/23. -There was no documentation that a 2nd step TB test was administered and read. -There was no documentation of a chest x-ray. Interview with the Resident Care Coordinator (RCC) on 03/19/24 at 1:49pm revealed: -Residents needed to have TB tests done before admission and needed their 2nd step TB test 30 days after admission. -She completed a chart audit a couple of months ago in her unit to see if the residents had chest x-rays or TB tests. -She did not complete a chart audit for all the residents in her unit due to staff shortages related to a communicable disease outbreak in the facility. -She was not aware the 2nd step TB test for Resident #3 had not been completed. Interview with the Care Services Director on 03/19/24 at 1:40pm and 2:03pm revealed: -The residents were required to have their 1st step TB test prior to admission and 2nd step TB test 4 weeks after admission. -The RCC were responsible for ensuring the residents in their assigned units had their 2nd step TB test. -The RCCs were trained by the facility to determine when TB tests were to be administered to residents. -The RCCs were to complete a chart audit for all the residents in the facility after January to ensure all residents had both steps of the TB test. -She was not notified that any residents in the facility had a missing TB test.	{D 234}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092206	A. BUILDING: _____ B. WING _____	R 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE	300 KILDAIRE WOODS DRIVE CARY, NC 27511

(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 234}	Continued From page 8 -She was a registered nurse (RN) and she or the Primary Care Provider (PCP) could have administered any TB tests that needed to be done. -She kept the solution to administer TB tests in the facility in case TB tests needed to be done. Based on observations and record review, it was determined Resident #3 was not interviewable.	{D 234}		