STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISB	361 LEONARD ROAD LOUISBURG, NC 27549

(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 complaint investigation on 08/04/21. The Franklin County Department of Social Services initiated the complaint investigation on 07/30/21.	D 000		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the plumbing system was maintained in a safe and operating condition which caused the facility to be without running water multiple times over a six-day period. The findings are: Interview with the Administrator on 07/30/21 at 10:00am revealed: -After the installation of a new water system on 07/27/21, the pipes started to burst, and the building started to flood the pump house. -The new water system was too forceful for the existing piping in the facility. -The high-pressured water caused the pipes to start to break apart and was leaking water into the facility. -When the pump house flooded, the electrical components shorted out and the only way to stop the pump house from flooding was to cut the water off.	D 105		

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-The plumber had recommended the whole piping system be redone on 07/28/21 and had begun working on the pipes.
-After the pipes started bursting, the staff was turning the water on and off throughout the day to supply water to the kitchen, flush commodes, and give partial baths on the 3rd hallway.
-The parts for the water system would be delivered on 07/31/21.
-Staff was turning the water on and off throughout the day.

Confidential interview with staff revealed:
-The water issue was much bigger than the Administrator was reporting.
-Several plumbers had been out to the facility to assess the situation.
-They had not observed anyone working on the water.
-The Administrator had been given repair quotes.

Interview with Administrator on 08/02/21 at 10:00am revealed:
-The water could not be repaired after the part was delivered on 07/31/21.
-The water had been on earlier today, 08/02/21, but had been shut off prior to the arrival of the staff with the Department of Social Services.

Observation of six community bathrooms on 08/04/21 between 8:15am-8:35am revealed:
-There were six commodes that contained stool and toilet paper and had not been flushed.
-There was no water dispensed when the faucets were turned to the on position.

Interview with the medication aide (MA) on 08/04/21 at 7:45am revealed:
-The facility did not have water this morning, 08/04/21.

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-The water had been "on and off" since 07/29/21.
-The last day they had water to turn "on and off" was on 08/02/21.

Interview with nine residents on 08/04/21 between 8:10am and 10:09am revealed:
-The commode could not be flushed because there was no running water.
-The commodes were not flushed for multiple days at a time.
-The commodes were dirty and full of stool and toilet paper.
-The commodes had not been flushed in two days.
-When they had to go to the bathroom, they had to use a commode that was already "used" by other residents.

Interview with a resident on 08/04/21 at 8:13am revealed:
-The water went out on Wednesday afternoon, 07/28/21.
-The water had been fixed but would go back out.
-It was unhealthy to have to live like this.
-The facility was uninhabitable without water.
-He went without a shower for almost a week.
-He was able to get a shower yesterday, 08/3/21.

Interview with a second resident on 08/04/21 at 8:10am revealed:
-The water had been "on and off" since 07/29/21.
-The plumbers would repair the broken pipe and another pipe would break.
-The resident took a shower "about a week ago."

Interview with a third resident on 08/04/21 at 8:35am revealed:
-They had not had water since 07/29/21 because the pipes kept bursting.
-He had not received any water to brush his teeth

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D 105	Continued From page 3 or wash his face. -He had a shower about a "week ago." Interview with a fourth resident on 08/04/21 at 10:09am revealed: -The plumbing in the facility was old. -The first plumber who came out did not know what they were doing. -The second plumber would repair what was broken. -Once the repair was completed something else would break. Interview with the Plumber/Electrician on 08/04/21 at 12:05pm revealed he had obtained the parts needed to repair the water and the water should be hooked up and turned on in "about" 30-minutes. Interview with the Administrator on 08/04/21 at 12:18pm revealed: -There was currently no water working in the facility, today, 08/04/21. -The first problem with the water was a pipe had burst in the kitchen on 07/29/21. -The plumber was called on 07/29/21 when the first pipe burst, and the pipe was fixed. -When the water was cut back on another pipe burst and the water was cut back off. -Over the weekend, 07/31/21-08/01/21, the water was being worked on by a plumber, and the facility staff were periodically able to cut the water on and flush the commodes. -The kitchen was closed by the local health department on 08/03/21 secondary to not having water in the building. -The water pipes bursting caused an electrical problem within the water pump. -When there was a pipe burst, she used a local plumber, but when it was identified as a "bigger	D 105		

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D 105	Continued From page 4 problem" she contacted a plumbing and electrical company that could handle the issue. Observation of the facility on 08/04/21 at 1:30pm revealed the water had been repaired and there were no immediate problems noted. Refer to Tag C338 10A NCAC 13G .0909 Resident Rights The facility's failure to ensure the water was working in the facility caused the residents to not be able to bathe, wash their hair and brush their teeth, flush the toilet after use, have adequate water to drink, and the residents did not have water available to wash their hands, which placed the residents at risk for infection and dehydration which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on 08/04/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 18,2021.	D 105		
D 338	10A NCAC 13F .0909 Resident Rights 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. This Rule is not met as evidenced by:	D 338		

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D 338	Continued From page 5 TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure all residents care and services were met when the water to the facility was disabled including residents who had to use commodes that were dirty and had not been flushed; not provided hand sanitizer in the bathrooms to use after toileting or hand sanitizer before a meal; were not provided water to brush their teeth or to drink; residents went without showers for several days and some were given baths from basins of cold water, and their residents clothes were not washed. The findings are: Review of the facility's resident roster revealed the facility's current census was 31 residents. Confidential interview with a staff member revealed the water issue was much bigger than management was reporting. Interview with the Administrator on 07/30/21 at 10:00am revealed: -Staff was turning the water on and off throughout the day. -The facility had a three-day reserve of bottled water on hand. -Laundry was being done offsite. -Residents were offered bottled waters, antibacterial wipes, and hand sanitizer throughout the day. -Resident baths were being done in bathrooms on the third hallway. Interview with the medication aide (MA) on 08/04/21 at 7:45am revealed: -The facility did not have running water this	D 338		

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D 338	Continued From page 6 morning, 08/04/21. -The water had been "on and off" since 07/29/21. -The last day they had running water was on 08/02/21. -Staff had been bringing in jugs of water to the facility to use with medication administration. Observation of water on hand on 08/04/21 at 9:08am revealed: -There were 32 sixteen-ounce bottles of water in an unopened package. -There were 18 of 32 sixteen-ounce bottles in a second package. -There were four jugs of water sitting on the floor; one was empty, one had less than sixteen ounces and two were full. -The Administrator thought there was additional water in the supply closet, but it was empty. Interview with the Administrator on 08/04/21 at 9:10am revealed: -She had been purchasing bottled water each morning. -Staff had been bringing in jugs of water from their homes. -She would send staff to purchase additional water today, 08/04/21. Observation of the local fire department personnel on 08/04/21 at 9:40am revealed they were pumping water into rolling trash cans. Interview with the Fire Chief with the local fire department on 08/04/21 at 9:45am revealed: -The fire department was called this morning, 08/04/21. -This was the only call received from the facility regarding the need for water. -The fire department brought 250 gallons of water and pumped into rolling trash cans.	D 338		

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D 338	Continued From page 7 -The water was used to flush commodes. -The water was not used for bathing or drinking. Observation of facility staff on 08/04/21 at 9:40am revealed the staff were rolling the trash cans full of water, to be used for flushing toilets, to the community bathrooms and emptying the water into the tubs. Second observation of water on hand on 08/04/21 at 10:20am revealed: -There were six - 24 packs of 16-ounce bottles of water, unopened, in the kitchen. -There was one - 32 pack of 16-ounce bottles of water, unopened, in the kitchen. -There was 13 - 16-ounce bottles of water in the kitchen. -There was 6 gallons of water in the kitchen. -There was 6 - 10-pound bags of ice in the freezer. Interview with a resident on 08/04/21 at 8:13am revealed: -The water went out on Wednesday afternoon, 07/28/21. -The water had been fixed but would go back out. -It was unhealthy to have to live like this. -The facility was uninhabitable without water. 1. Observation of the facility on 08/04/21 at 7:45am revealed a rancid odor of urine and stool. Interview with a resident on 07/30/21 at 11:00am revealed residents were told the commode could be used but not flushed after each use. Observation of six community bathrooms on 08/04/21 between 8:15am-8:35am revealed: -All six bathrooms were unflushed and contained stool and toilet paper.	D 338		

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D 338	Continued From page 8 -Three of the commodes had stool smeared on the seat. Observations of commodes in thirteen residents' rooms on the 300-hall on 08/04/21 between 8:10am - 11:00am revealed commodes in the bathroom adjoining two bedrooms were unflushed and contained stool and toilet paper. Interview with the medication aide (MA) on 08/04/21 at 7:45am revealed: -The residents were using the commodes and not flushing because there was no running water. -The residents were not washing their hands. Interview with a resident on 08/04/21 at 8:10am revealed: -The commode could not be flushed because there was no running water. -He had stopped using the commode in the bathroom adjoining two bedrooms and started using the commode in the community bathroom. Interview with a second resident on 08/04/21 at 8:13am revealed: -The commodes were not flushed for multiple days at a time. -The commodes were flushed yesterday, 08/03/21, but they had not been flushed since then. -The smell was horrible, "you almost vomit just walking down the hall." Interviews with eleven other residents on 08/04/21 from 8:20am to 10:09am revealed: -The residents used the commode but could not flush because there was no running water. -The commodes were dirty and full of stool and toilet paper. -The commodes had not been flushed in two	D 338		

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days.
-When they had to go to the bathroom, they had to use a commode that was already "used" by other residents.
-There was an odor in the building related to the unflushed commodes.

Interview with a housekeeper on 08/04/21 at 9:01am revealed:
-He had used water from the leaking hot water tank yesterday, 08/03/21, to mop the floors.
-He used the mop water to flush a commode.
-There was a water truck coming today, 08/04/21 at 9:30am.
-He was going to flush the commodes with the water.

Interview with the Administrator on 08/04/21 at 9:10am revealed there had been intermittent water available to flush commodes when they were turning the water "off and on" between pipes bursting.

Observation of six community bathrooms on 08/04/21 at 9:58am revealed:
-The housekeeper and maintenance staff were going into each bathroom and dipping water from a trash can using a bucket and pouring the water into the commodes.
-Three commodes were not cleaned and had stool smeared on the seats.

Observation of the community bathrooms on 08/04/21 between 10:00am-11:24am revealed residents using the bathrooms.

Observation of six community bathrooms on 08/04/21 at 11:24am revealed the commodes had been used and contained toilet paper and stool.

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D 338	Continued From page 10 Interview with the Resident Care Coordinator (RCC) on 08/04/21 at 10:04am revealed the commodes had been flushed every time the water came on and before the water was turned back off because of a new problem. Interview with a personal care aide (PCA) on 08/04/21 at 11:02 revealed: -She would leave the facility to use the bathroom. -She did not want to "add to the mess". Interview with the Administrator on 08/04/21 at 11:24am revealed: -She did not know the residents had used the commodes and they had not been flushed again. -She had not asked any staff to keep the commodes flushed. -She had not "gotten that far." -She was focused on getting the water turned on in the facility. -She would have someone flush the commodes and monitor. Observation of six community bathrooms on 08/04/21 at 11:35am revealed: -The housekeeper and maintenance staff were going into each bathroom and dipping water from a trash can using a bucket and pouring the water into the commodes. -The three commodes were not cleaned and still had stool smeared on the seats. 2. Observation of six community bathrooms on 08/04/21 between 8:15am-8:35am revealed there was no hand sanitizer or sanitizing wipes available to be used by the residents. Interview with the medication aide on 08/04/21 at 7:45am revealed: -The residents were using the commodes and not	D 338		

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flushing.
-The residents were not washing their hands.

Observation of the clean storage room on 08/04/21 revealed about 70 bottles of hand sanitizer.

Observation of two staff bathrooms on 08/04/21 at 8:45am revealed there was no hand sanitizer available to be used.

Observation of a resident's room on 08/04/21 at 9:23am revealed:
-A staff member brought in one bottle of hand sanitizer and placed the bottle on a resident's bedside table.
-The second resident was not provided a bottle of hand sanitizer.

Interview with the two residents on 08/04/21 at 9:23am revealed no one had offered hand sanitizer until today, 08/04/21.

Interview with the medication aide (MA) on 08/04/21 at 7:45am revealed:
-The residents were using the commodes and not flushing because there was no running water.
-The residents were not washing their hands because there was no running water.

Interview with the Administrator on 08/04/21 at 12:49pm revealed:
-She did not know the bathrooms did not have hand sanitizer.
-The housekeeper should have been making sure there was hand sanitizer in each bathroom.
-She had not told housekeeping to monitor the bathrooms for hand sanitizer.
-She had been focused on obtaining food for the residents and getting the water repaired today,

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08/04/21.
-She had not checked on the hand sanitizer in the bathrooms.
-She had used hand sanitizer in a bathroom "down the hall" in the last "couple of days."

Second interview with the Administrator on 08/04/21 at 2:33pm revealed:
-She honestly thought the bathrooms had hand sanitizer available to be used after the residents toileted because of the plumbing issues that began on 07/29/21.
-She was concerned the residents were eating after using the bathroom and had not washed their hands.
-She was not sure what the staff had been doing related to encouraging the use of hand sanitizer.

3. Observation of two residents in their room on 08/04/21 at 9:30am revealed:
-They were served biscuits and juice for breakfast.
-The residents were not offered hand sanitizer prior to eating.
-There was no hand sanitizer in their room.

Observation of two residents in their room on 08/04/21 at 8:38am revealed:
-The residents were told by a personal care aide (PCA) that breakfast was being served.
-The residents left their room and entered the dining room.
-The residents picked up a biscuit with their hands.
-No one offered the residents hand sanitizer or wipes before eating their breakfast.

Observation of a third resident on 08/04/21 at 8:38am revealed:
-She entered the dining room rolling the wheels of

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her wheelchair with her hands.
-She was not offered hand sanitizer.
-She picked up a biscuit with her bare hands and held the biscuit to eat.

Observation of the dining room on 08/04/21 at 8:52am revealed a staff member entered the dining room and handed out wipes to the residents to wipe their hands after eating breakfast.

Interview with a resident on 08/04/21 at 9:46am revealed:
-She had been eating without washing her hands.
-Today was the first day anyone had offered her a wipe to wipe her hands.

Interview with the Resident Care Coordinator (RCC) on 08/04/21 at 10:04am revealed:
-She did not know residents were eating meals without sanitizing their hands.
-Staff had always known the residents should wash their hands before meals.

Observation of the lunch meal service on 08/04/21 at 12:10pm revealed each resident was given hand sanitizer to clean their hands upon entry into the dining room.

4. Interview with thirteen residents on 08/04/21 between 8:35am-9:46am revealed:
-They had not had water since 07/29/21.
-The residents had not received any water to brush their teeth or wash their face.
-They had not asked for water to brush their teeth because if there was not enough water to drink, they knew there would not be any to "spare for that."

Interview with personal care aide (PCA) on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035031	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHERN LIVING FOR SENIORS OF LOUISB	361 LEONARD ROAD LOUISBURG, NC 27549

(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 338	Continued From page 14 08/04/21 at 3:05pm revealed residents were offered a cup of water to brush their teeth. Interview with the Administrator on 08/04/21 at 12:18pm revealed the residents had been provided water to brush their teeth. Interview with the Resident Care Coordinator (RCC) on 08/04/21 at 3:05pm revealed: -She expected staff to offer bottled water to the residents. -She did not know the staff had not offered bottled water to the residents to brush their teeth. 5. Observation of water on hand on 08/04/21 at 9:08am and 10:20am revealed: -There were 32 sixteen-ounce bottles of water in an unopened package. -There were 18 of 32 sixteen-ounce bottles in a second package. -There were four jugs of water sitting on the floor; one was empty, one had less than sixteen ounces and two were full. -There were six twenty-four packs of 16-ounce bottles of water, unopened, in the kitchen. -There were six-gallon jugs of water, unopened, sitting on the kitchen counter. -There were six ten-pound bags of ice in the freezer. Interviews with thirteen residents on 08/04/21 between 8:13am-10:09am revealed: -The facility staff were being "tight" with the water they had. -If you asked for water, they did not want to give it out. -He had asked for water to drink and was told they did not have any to spare. -The staff did not provide bottle water to residents when asked.	D 338		

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D 338	Continued From page 15 -The resident witnessed other residents requesting bottled water and were denied. -She was thirsty. -No one had offered her bottled water to drink. -Another resident told her bottled water was not available, so she had not asked for water to drink. Interview with the Administrator on 08/04/21 at 9:10am revealed: -Most of the residents had their own sodas to drink. -The residents could go to the kitchen and ask for water to drink. Interview with the Resident Care Coordinator (RCC) on 08/04/21 at 10:04am revealed: -Every resident had been offered water to drink at every meal and with every snack. -There had been plenty of water to drink for the residents. -The facility always kept a three week supply of water on hand in case of an emergency and the Administrator was buying water as needed. 6. Confidential interview with a staff member revealed: -The water issue was much bigger than management was reporting. -Only a few residents had been given baths. -Residents were cleaned with adult wipes. Interview with a personal care aide (PCA) on 08/04/21 at 8:00am revealed: -They were using wipes for hygiene care to incontinent residents. -They would heat water on the stove in the kitchen and pour in a basin to provide warm water for a "sink" bath. -The residents had not received a bath today, 08/04/21.	D 338		

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D 338	Continued From page 16 -The PCA was waiting for the water to be repaired to give baths. Interview with a resident on 08/04/21 at 8:10am revealed: -The resident took a shower "about a week ago". -The water had been "on and off" since 07/29/21. Interview with a second resident on 08/04/21 at 8:30am revealed the resident had not showered in a week. Interview with a third resident on 08/04/21 at 8:13am revealed: -He went without a shower for almost a week. -He was able to get a shower yesterday, 08/03/21. Interview with a fourth resident on 08/04/21 at 9:13am revealed: -She had not had a shower, and her hair was greasy. -No one had offered a bath to her in over a week. Interview with a fifth resident on 08/04/21 at 9:16am revealed: -Staff assisted her with a "pan" bath 4-5 days ago. -The water was cold, and the staff poured the water straight into the pan. -She had not been able to wash her hair, and she thought it was dirty and greasy. Observation of two resident's hair on 08/04/21 at 9:16am revealed both resident's hair was oily. Interview with a sixth resident on 08/04/21 at 9:25am revealed: -The resident was unable to wash their hair. -The resident had not had a shower in five days.	D 338		

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D 338	Continued From page 17	D 338		

-The staff provided the resident a pan of cold water to bathe.
-The resident used the same pan of water for five days.

Observation of a resident's room on 08/04/21 at 9:25am revealed:
-There was a pan of brownish gray water sitting on the bedside table.
-There was a build up of grime on the inside of pan at the water line.

Interview with a seventh resident on 08/04/21 at 9:46am revealed:
-She had not had a shower in over a week.
-She had a "wash up" a couple of days ago from a pan of cold water.
-She was "about froze" when she finished her "wash up."
-She felt uncomfortable and wanted to be clean.
-Her hair was dirty, and her head was itching.

Interview with the Resident Care Coordinator (RCC) on 08/04/21 at 10:04am revealed:
-She did not know residents had been given baths using cold water.
-She had not told the staff to warm the water but assumed they would know to do so.
-No one wanted to have a cold bath.
-Staff should have warmed the water up before helping the residents with a bath by warming the water in the microwave.
-She took two residents to her home on Saturday, 07/31/21 to get a shower.

7. Interview with the Administrator on 07/30/21 at 10:00am revealed the laundry was being done offsite.

Interview with a resident on 08/04/21 at 8:13am

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D 338	Continued From page 18 revealed: -All of his clothes were dirty. -He wanted to wash his clothes yesterday, 08/03/21, but could not because there was no water. -He had to wear dirty clothes. Observation of three resident rooms on 08/04/21 between 8:32am-9:58am revealed each resident had a clothes basket that was over the rim of the basket, full of dirty clothes. Observation of the laundry room on 08/04/21 at 8:55am and 10:00am revealed: -A bag that contained soiled clothing was on the floor behind the door. -There was a pile of soiled clothing and linens laying on the floor behind the door. Interview with two residents on 08/04/21 at 9:13am revealed their clothes needed to be washed and they had been wearing the same clothes for several days. Interview with the Resident Care Coordinator (RCC) on 08/04/21 at 10:04am revealed: -The facility had water on Monday, 08/02/21, and staff were washing bed linens. -She did not know how much laundry was done on 08/02/21 before the water went out again. Interview with the Administrator on 08/04/21 at 2:33pm revealed: -They had kept up with washing the laundry the best they could. -They had not had to go to the laundromat yet but talked about it yesterday, 08/03/21. _____ The facility failed to provide appropriate care and services for the residents by not providing hand	D 338		

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D 338	Continued From page 19 sanitizer to the residents after toileting and before eating. There were multiple residents whose hair was oily and the residents complained of not having a bath for several days and when they were provided a pan of water to take a bath and the water was not warm. The residents complained of being thirsty and were told water needed to be conserved. The residents complained of having to use the bathroom in a commode that had not been flushed. The residents had to wear dirty clothes because the laundry had not been washed. The facility's failure resulted in serious neglect to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 on 08/04/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 3,2021.	D 338		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations	D912		

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D912	Continued From page 20 as related to resident rights and other requirements. The findings are: 1. Based on observations and interviews the facility failed to ensure the plumbing system was maintained in a safe and operating condition which caused the facility to be without running water multiple times over a six-day period. [Refer to Tag 105, 10A NCAC 13F .0311(a) Other Requirements (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure all residents care and services were met when the water to the facility was disabled including residents who had to use commodes that were dirty and had not been flushed; not provided hand sanitizer in the bathrooms to use after toileting or hand sanitizer before a meal; were not provided water to brush their teeth or to drink; residents went without showers for several days and some were given baths from basins of cold water, and their residents clothes were not washed. Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].	D912		