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D 000	Initial Comments The Adult Care Licensure Section conducted an Annual survey on March 18, 2015, March 19, 2015 with an exit conference via telephone on March 20, 2015.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation and interviews, the facility failed to assure cleaning agents used by 2 residents (Resident #4 and #5) were stored in a separate locked area when not in use and monitored by staff and were stored in a resident's room (Room #102) which could be hazardous if ingested or inhaled. The findings are: Observation on 3/18/15 at 8:45 am and 12:35 pm of a male cleaning 7 tables in the residents' dining room using a white quart-size spray bottle with no label and a white cleaning cloth. Interview on 3/18/15 at 12:35 pm with Resident	D 056		

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#4, who was cleaning dining room tables revealed:
-He was a resident of the facility.
-He liked to help clean the facility because "it gives me something to do."
-He cleaned the tables in the residents' dining room after each meal.
-The substance in the unmarked white quart-size bottle contained "a little bleach and water."
-The facility staff provided him with cleaning supplies to use when cleaning.
-He had been volunteering to clean for several months.

Review of the current FI-2 dated 9/30/14 for Resident #4 revealed:
-He was admitted to the facility on 7/30/14.
-His diagnoses included pancreatitis, Failure to thrive, Chronic Obstructive Pulmonary Disease, Hypertension, and Post Traumatic Stress Disorder.
-His cognitive status was oriented.

Observation of the laundry room located across from Resident Room #102 during the initial tour on 03/18/15 at 9:00 am revealed:
-The door to the laundry room was open and unlocked.
-A white quart-size spray bottle marked "3rd shift bleach" on the bottle.
-An unmarked white quart-size spray bottle containing a yellow liquid.
-A white quart-size spray bottle marked with the name of a multi-purpose cleaning agent written in black on the bottle.
-A white unlabeled quart-size spray bottle containing a liquid that smelled like a cleaning agent with the trigger pull unscrewed.
-All of the quart-size spray bottles were located on a wire shelf to the right of the entry to the

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D 056	Continued From page 2 laundry room. Interview on 03/18/15 at 9:10 am with Resident #5 who resided in Room #102 revealed: -"We have assigned laundry days". -He used the washer and dryer located in the laundry room to wash his clothes. -Staff would assist him with his laundry, but he preferred to do it himself. Further interview on 03/19/15 11:35 am Resident #5 revealed: -There were six built-in closets for residents' storage. -Each resident had two closets. -The first closet on the left was "the chemical closet" where another resident who resided in Room #102 kept cleaning supplies "because he helps clean" the facility. -"Staff knows that the chemicals are in here." -"They know that it is not dangerous for the chemicals to be in this room with the three of us." -"There are some people that live here that you wouldn't have chemicals in their rooms." -"No one has bothered the chemicals." Review of the record of Resident #5 revealed: -He was admitted to the facility on 10/29/14. -A current FI-2 signed 11/25/14 with diagnoses including schizophrenia, alcohol use disorder (mild), seizure disorder, and traumatic brain injury. -Review of the care plan dated 10/29/14 revealed documentation the resident was sometimes disoriented and forgetful. Observation of Room #102 on 03/19/15 at 11:40 am revealed: -A built-in closet located in the first position in a set of three closets on the left in Resident Room	D 056		

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#102 that was unlocked.
-The built-in closet had a latch on the right side of the closet door, but did not have a lock.
-A two-thirds full 1.12 gallon size container of a general purpose cleaning agent and disinfectant located at the bottom of the closet.
The manufacturer's warning label included: (1) May react with bleach-containing products or other household cleaners to produce hazardous gases (2) Avoid contact with skin, eyes, or clothing (3) Causes mild skin irritation - If skin irritation occurs, get medical advice.
-Two quart-size manufacturer's spray bottles of a non-aerosol air freshener and deodorizer.
-One bottle of air freshener and deodorizer was three-fourths full.
-One bottle of air freshener and deodorizer was one-eighth full.
-Precautionary statements on the two bottles of air freshener included (1) May cause mild eye and skin irritation. (2) May be harmful if swallowed. (3) Inhalation of product mist may cause respiratory irritation. (4) Avoid contact with eyes, skin or clothing. (5) Do not swallow.
-A white quart-size spray bottle that was half full with a liquid and the name of a general purpose cleaning agent and disinfectant written on the bottle in black ink.
-A supply of white cleaning clothes.
-A supply of brown paper towels.
-Four empty white quart bottles, one that had the letter "B" written on it.

Second interview on 03/19/15 at 11:45 am with Resident #4 revealed:
-The Resident Care Director (RCD) allowed him to keep cleaning supplies in his closet for easy access as he cleaned daily as well as for third shift staff who cleaned at night.
-"There is a chemical closet, but staff lets me

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keep cleaning supplies for third shift."
-He utilized the chemicals to clean tables in the dining room as well as to clean toilets and the floors of the facility.
-The RCD was to obtain a lock for the closet.
-None of the residents of Room #102 would misuse the chemicals, but there were residents in the facility that might "if they could get to it."
-The third shift staff obtained cleaning supplies from the closet in Resident Room #102 because "the chemical closet is locked" and they did not have a key.

Further interview with Resident #4 on 03/19/15 at 12:32 pm revealed:
-The white quart bottles in his closet were ones that had previously contained cleaning chemicals and he reused the bottles.
-He took cleaning supplies out of his closet daily for third shift because they did not have a key to the locked cleaning supply closet of the facility.

Interview on 03/19/15 at 12:25 pm with the RCD revealed:
-She had told a resident who resided in Room #102 that he could keep "a few cleaning supplies" in his closet a few months ago.
-She was unaware of the amount of cleaning supplies that were stored in Resident Room #102.
-The cabinet was unlocked during the day while Resident #4 volunteered to clean in the facility.
-She had a lock that she put on the closet daily when she left the facility, but she did not open the closet door to see what was in the closet.
-The third shift staff were responsible for cleaning the facility, but did not have a key to the chemical closet.
-She was aware that Resident #4 removed cleaning supplies from his closet for third shift

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D 056	Continued From page 5 staff to use each night. -She locked the cleaning supplies in the medicine room each day at the end of her shift, but did not look in the closet in Room #102 when she locked it each day. -She was not aware that there were bottles containing chemicals in the laundry room. -Residents used the laundry room for washing their clothes. -She would remove the bottles with chemicals immediately and place them in the locked chemical closet. Observation on 03/19/15 at 12:35 pm revealed a resident and the RCD removed the chemicals from the resident's closet in Room #102 and placed them in the locked chemical closet. Interview on 03/19/15 at 12:50 pm with the Corporate Administrator revealed: -She was unaware that chemicals were stored in an unlocked closet in Resident Room #102. -A resident in Room #102 "volunteers to clean" and performs tasks such as cleaning the tables in the dining room, sweeping, and mopping. -The facility's policy was to have all chemicals in a location that was locked and not located in a resident's room. -The facility did have residents with mental health diagnosis who could be at risk for misusing chemicals. -There had been no incidents with residents misusing chemicals that were stored in Resident Room #102. The facility provided the following Plan of Protection on 04/03/15: -All chemical containers were removed immediately. -All chemicals are locked in an assigned area and	D 056		

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D 056	Continued From page 6 only staff has a key. -The chemical closet will remain locked at all times. -The RCD will monitor daily to ensure that the chemical closet is locked. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 4, 2015.	D 056		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the walls, ceilings, and floors were clean and in good repair in 2 of 10 residents' rooms (Room #103 and #108). The findings are: Observation of the facility layout out during the initial tour on 3/18/15 revealed the facility had 2 halls, [Hall A (Rooms #101, #102, #103, #104) and Hall B (Rooms #105,#106, #107, #108, #109, #110)], a dining area with alcove (dayroom), and a lobby/foyer. A. Observation of Room #108 on 3/18/15 at 9:30 am during facility tour revealed: - Two residents resided in the room. - Directly overhead at the entry door there were 2 approximately 24 inch by 48 inch ceiling tiles and	D 074		

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D 074	Continued From page 7 a partial ceiling tile missing, exposing multiple flexible duct pipes, a heating/cooling unit and a metal pan (approximately 24 inch by 72 inch and 4 inches deep). - Five additional ceiling tiles with stains were located throughout the room. Interview on 3/18/15 at 9:30 am with one of the residents residing in Room #108 revealed: - He had resided at the facility more than 3 years. - The ceiling tiles had been missing for 5 or 6 months due to repair work done to the heating/cooling unit for a leak in the drain. - The temperature in the room was comfortable for the time the ceiling tiles had been missing. - Staff were aware of the missing tiles, but nobody had come the room to replace the tiles. - He thought the stains on the ceiling tiles came from the leaking drain. Interview on 3/19/15 at 4:30 pm with the second resident residing in room #108 revealed: - The ceiling tiles had been missing for 4 to 5 months. - The missing tiles did not bother him. - He had not experienced noticeable change in the room temperature since the ceiling tiles had been missing. Interview on 3/18/15 at 3:55 pm with Management Company Administrator revealed: - The ceiling tiles were replaced with fire rated tiles about a year ago. - The facility did not have the replacement tiles. - The heating/cooling repair company removed the damaged tiles below the unit when repairs were made. - The heating/cooling company had informed the facility that they were not responsible to replace the tiles.	D 074		

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D 074	Continued From page 8 - The building owner/Administrator had been contacted a few months ago after the repair to the heating/cooling unit and drainage was repaired. - The ceiling tile company had been had contacted by the building owner 2 to 3 weeks ago, but they had not come to the building to replace tiles. Interview on 3/19/15 at 4:00 pm with the building owner/Administrator revealed: - He had hired a ceiling contractor to replace all the building's ceiling tiles last year following the survey by Construction. - The ceiling tiles were fire rated and had to be custom installed by a contractor. - The facility notified him that the heating/cooling unit needed repairs and ceiling tiles were damaged a few months ago (not sure of the exact date). - The facility had requested the ceiling tiles be replaced, but he had experienced problems contacting the original contractor. - He stated he had spoken with the contractor, but was not aware the repairs had not been completed. - He stated he would contact the contractor again today (3/19/15). Interview on 3/19/15 at 4:35 pm with an evening shift medication aide revealed: - The ceiling tiles in room #108 had been missing for 4 to 5 months. - The residents had not complained to her about the missing tiles. - She felt certain management was aware of the missing tiles. Interview on 3/19/15 at 4:45 pm with the Corporate Administrator revealed she was aware	D 074		

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D 074	Continued From page 9 of the missing tiles, but she had not requested for maintenance to replace the tiles. Interview on 3/19/15 at 4:45 with the Resident Care Director (RCD) revealed: - She was aware the ceiling tiles were missing from room #108. - The ceiling tiles had been missing for several months. - The heating/cooling repair company was at the facility on 1/27/15, but did not mention the tiles. - The Corporate Administrator knew about the missing ceiling tiles and was working on getting them replaced. - No residents had complained to her about stained or missing ceiling tiles. B. Observation of Room #103 on 3/18/15 at 9:20 am during facility tour revealed: -Four residents resided in the room. -Four approximately 24 inch by 48 inch ceiling tiles located overhead and in front of the double sink area in the residents' room had dark brown stains. -One approximately 24 inch by 48 inch ceiling tile located on the right far ceiling with a dark brown stain. -Measurements of the stains for each ceiling tile was approximately two tiles with a stain 6 inches in diameter, one tile with a stain 3 inches in diameter and one tile with multiple small brown stains that were approximately one-half inch in diameter. -Two of 7 fluorescent light fixtures (each constructed to contain 4 bulbs) had dark brown stains inside the covers. -Measurements of the dark brown stains inside each light fixture cover was approximately one cover with a 24 inch by 9 inch stain, one cover with a 12 inch by 4 inches.	D 074		

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D 074	Continued From page 10 -A double sink with a cabinet measuring approximately 5 feet in width with dark brown stains on the bottom wooden baseboard with the stains extending the length of the cabinet. -Tile flooring in front of the double sink cabinet measuring approximately 4 feet in width with dark brown stains on the floor tile extending 4 to 6 inches in front of the cabinet. Observation on 03/19/15 at 1:45 pm of the Maintenance Contract worker painting the walls in Room #103. Interview on 3/19/15 at 1:45 pm with a resident of Room #103 revealed: -The ceiling tiles and the light fixture covers had been stained "for awhile", but he did not know how long. -The bottom of the sink cabinet and the floor in front of the sink was stained due to the sink overflowing with water. -The water had been turned off to both sinks since the previous week due to plumbing issues. -Staff had contacted a plumber who was to be coming soon to fix the sink. -The resident used a sink in a common bathroom when needed. -Staff had tried to clean the cabinet and the floor with several cleaning agents, but could not remove the stains. Interview on 3/18/15 at 9:22 am with another resident of Room #103 revealed: -There were plumbing problems with the toilet and the sink in their room and the water had been turned off to both the toilet and the sink since last week. -Staff had contacted a plumber who was to be coming to fix the plumbing.	D 074		

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D 074	Continued From page 11 Interview with the Resident Care Director (RCD) on 10/19/15 at 10:30 am revealed: -She was previously employed at the facility and returned in September 2014 as the RCD. -She was aware that there were multiple brown stains on the ceiling tiles, light covers, bottom of the sink cabinet and floor in front of the double sink area of resident room #103. -She was not sure of the cause for the stains on the ceiling tiles and light covers. -The cause of the brown stains on the bottom of the sink cabinet was from a resident residing in room #103 had previously been making "sock coffee" in his room. -The resident would put instant coffee in a sock and run water over it to make coffee. -Staff had talked with the resident and he no longer made "sock coffee" in his room. -She and a Personal Care Aide had tried to clean the bottom of the sink cabinet and the floor in front of the sink with several cleaning agents, but could not remove the stains. Interview with the Maintenance Contractor on 3/19/15 at 11:00 am revealed: -He had already replaced some ceiling tiles in the hallways and in some of the residents' rooms. -He could not recall which rooms he had replaced the ceiling tiles. -He was in the process of painting every room. -His company came to see what needed to be repaired and they then ordered the materials and sent him to complete the repairs.	D 074		
D 088	10A NCAC 13F .0306(b)(2) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings	D 088		

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D 088	Continued From page 12 (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (2) a bedside type table; 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 provide bedside tables for 4 of 10 resident's rooms (Rooms #102, #103, #107, and #108) and failed to maintain bedside tables in good repair for 1 of 10 residents' rooms (Room #103) as required. The findings are: A. Observations during facility tour on 03/18/15 from 8:45 am to 9:45 am of Hall A (Rooms #101, #102, #103, #104) revealed: -Room #101 had 3 residents and 3 bedside tables. -Room #102 had 3 residents and 2 bedside tables. -Room #103 had 4 residents and two bedside tables. -Both bedside tables in Room #103 had handles missing. -Room #104 had 4 residents and 4 bedside tables. Interview on 03/19/15 at 11:30 am with a resident who resided in Room #102 revealed he had sufficient storage and did not feel he needed a bedside table. Interview on 03/19/15 at 1:45 pm with a resident who resided in Room #103 revealed: -He was not sure how long the handles had been missing off of his bedside table.	D 088		

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D 088	Continued From page 13 -He was able to open the drawer to the bedside table. -He had not reported to anyone that the handles were missing on his bedside table. Refer to interview with the Resident Care Director (RCD) on 03/19/15 at 5:30 pm. Refer to interview with Corporate Administrator on 03/19/15 at 12:50 pm. B. Observation during facility tour on 3/18/15 from 8:45 am to 9:45 am of Hall B (Rooms 105,106,107,108,109,110) revealed: -Room # 107 had 2 residents and 0 bedside tables. -Room # 108 had 2 residents and 1 bedside table. Interview with a resident on 3/19/15 at 11:20 am revealed: -He had resided in the facility for 6 months. -He had never had a bedside table in his room. -He had never requested a bedside table to administration. -He would use a bedside table if he had one. Refer to interview with the Resident Care Director (RCD) on 03/19/15 at 5:30 pm. Refer to interview with Corporate Administrator on 03/19/15 at 12:50 pm. _____ Interview on 03/19/15 at 5:30 pm with the RCD revealed she had received no requests from residents for repairs to bedside tables or for the purchase of a bedside table. Interview with the Corporate Administrator on	D 088		

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D 088	Continued From page 14 03/19/15 at 12:50 pm revealed: -The facility had purchased bedside tables and dressers over the past two years. -She was not aware that 6 residents did not have bedside tables. -She had not received any requests from residents for a bedside table. -She was not aware that there were handles missing on 2 bedside tables.	D 088		
D 090	10A NCAC 13F .0306(b)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (4) a wall or dresser mirror that can be used by each resident; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to furnish a wall or dresser mirror in 7 out of 10 residents' rooms that could be used by each resident (Rooms #102, #105, #106, #107, #108, #109, and #110). A. Observations during facility tour on 03/18/15 from 8:45 am to 9:45 am of Hall A (Rooms #101, #102, #103, #104) revealed Room #102 had no mirror and three residents. Interviews with 3 residents who resided in Room #102 on 03/18/15 at 3:30 pm revealed: -They used the mirrors that were on the wall in the dining room across from their room.	D 090		

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D 090	Continued From page 15	D 090		

-There was a mirror above the sink in the bathroom adjoined to the bedroom.
-One resident had considered purchasing a mirror at a local thrift store, but had not.
-They had not requested a mirror from staff at the facility.

Observation on 03/18/15 at 3:50 pm revealed there were floor to ceiling mirrors on one wall in the dining room located across from Room #102.

Refer to interview with a Personal Care Aide on 03/19/15 at 2:30 pm.

Refer to interview with the Resident Care Director on 03/19/15 at 5:30 pm.

Refer to interview with the Corporate Administrator on 03/20/15 at 3:00 pm.

B. Observation during facility tour on 3/18/15 from 8:45 am to 9:45 am of Hall B (Rooms #105, #106, #107, #108, #109, and #110) revealed:
-Room #105 had three residents and no mirrors.
-Room #106 had two residents and no mirrors.
-Room #107 had two residents and no mirrors.
-Room #108 had two residents and no mirrors.
-Room #109 had three residents and no mirrors.
-Room #110 had two residents and no mirrors.

Interview with a resident from one of the rooms mentioned above on 3/18/15 at 3:55 pm revealed:
-He had never had a mirror in his room.
-He had to go to the shared bathroom to get ready.
-He would like to have a mirror in his room.
-He had never requested a mirror to administration.

Interview with a resident from one of the rooms

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D 090	Continued From page 16 mentioned above on 3/19/15 at 2:15 pm revealed: -He had never had a mirror in his room. -He goes to the bathroom across the hall if he needs a mirror. -He had never requested a mirror to administration. Refer to interview with a Personal Care Aide (PCA) on 03/19/15 at 3:30 pm. Refer to interview with the Resident Care Director on 03/19/15 at 5:30 pm. Refer to interview with the Corporate Administrator on 03/20/15 at 3:00 pm. _____ Interview with a PCA on 3/19/15 at 2:30 pm revealed: -Since she began employment, did not recall mirrors ever being in the rooms. -As far as she knew, residents had not complained about not having mirrors in their rooms. Interview on 03/19/15 at 5:30 pm with the Resident Care Director revealed she had received no requests from residents for mirrors in their rooms. Interview with the Corporate Administrator on 03/20/15 at 3:00 pm revealed: -She was unaware that there were no mirrors in the resident's rooms. -She had not received requests from residents for mirrors. -The facility had not purchased any mirrors since she had been Corporate Administrator for two years.	D 090		

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D 091	Continued From page 17	D 091		
D 091	10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors; 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 provide a minimum of one comfortable chair for each resident in 10 of 10 resident bedrooms (Rooms #101, #102, #103, #104, #105, #106, #107, #108, #109, and #110). The findings are: A. Observations during facility tour on 03/18/15 from 8:45 am to 9:45 am of Hall A (Rooms #101, #102, #103, and #104) revealed: -Room #101 had three residents and no chairs. -Room #102 had three residents and one chair. -Room #103 had four residents and no chairs. -Room #104 had four residents and no chairs. -The dining room located on the opposite side of the hall from rooms #101, #102, #103, and #104 had 24 chairs utilized for meals for residents. Observation during lunch meal on 03/18/15 at 12:15 pm revealed there were enough chairs in	D 091		

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D 091	Continued From page 18	D 091		

the dining room to serve the residents that came to the dining room for the meal.

Interviews with 5 residents who resided in Rooms #101, #102, #103, and #104 on 03/19/15 from 1:30 pm to 1:50 pm revealed:
-The residents were unaware that the facility was supposed to provide each resident with a comfortable chair.
-Four of 5 residents interviewed did not want a chair in their room.
-One of 4 residents interviewed wanted a chair in their bedroom.
-Two residents said that they would sit in the lobby area or borrow a chair from the dining room area when they had visitors.

Refer to interview with a Personal Care Aide (PCA) on 03/19/15 at 2:30 pm.

Refer to interview with the Resident Care Director (RCD) on 03/19/15 at 5:30 pm.

Refer to interview with the Administrator on 03/20/15 at 3:00 pm.
B. Observation during facility tour on 3/18/15 from 8:45 am to 9:45 am of Hall B (Rooms #105, #106, #107, #108, #109, and #110) revealed:
-Room #105 had three residents and no chairs.
-Room #106 had two residents and no chairs.
-Room #107 had two residents and no chairs.
-Room #108 had two residents and no chairs.
-Room #109 had three residents and no chairs.
-Room #110 had two residents and no chairs.

Interview with a resident from one of the above mentioned rooms on 3/18/15 at 3:55 pm revealed:
-He had never had a chair in his room.
-He would like to have a chair in his room for

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D 091	Continued From page 19 visitors. -He had never requested a chair for his room to administration. Interview with a resident from one of the above mentioned rooms on 3/19/15 at 11:25 am revealed: -He had never had a chair in his room. -"It would be nice to have one for my mom when she visits." Interview with a resident from one of the above mentioned rooms on 3/19/15 at 2:15 pm revealed: -He had never had a chair in his room. -"I could use a chair in my room." -He had never requested a chair in his room to administration. -He used the front foyer area when visitors came for sitting. Refer to interview with a Personal Care Aide (PCA) on 03/19/15 at 2:30 pm. Refer to interview with the Resident Care Director (RCD) on 03/19/15 at 5:30 pm. Refer to interview with the Corporate Administrator on 03/20/15 at 3:00 pm. _____ Interview with a PCA on 3/19/15 at 2:30 pm revealed: -Since she began employment, did not recall chairs ever being in the rooms. -As far as she knew, residents had not complained about not having chairs in their rooms. -When visitors came, they sat on the residents' beds or went to the dining room.	D 091		

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D 091	Continued From page 20 Interview with the RCD on 03/19/15 at 5:30 pm revealed: -She was previously employed at the facility and returned in September 2014 as the RCD. -She had received no requests from residents for a chair in their room. Interview with the Corporate Administrator on 03/20/15 at 3:00 pm revealed: -She was unaware that a chair was to be provided for each resident. -She had not received requests from residents for chairs in their rooms. -The facility had not purchased any chairs for residents' rooms since she had been Corporate Administrator for two years.	D 091		
D 093	10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading. 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 assure there was a light overhead of the bed with a switch within reach of residents lying in bed or a bedside lamp for 10 of 10 residents' rooms (Rooms	D 093		

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D 093	Continued From page 21 #101, #102, #103, #104, #105, #106, #107, #108, #109, and #110). The findings are: Observations during facility tour on 03/18/15 from 8:45 am to 9:45 am of Hall A (Rooms #101, #102, #103, #104) revealed: -An on/off switch located next to the left of the entrance door of each room that operated multiple overhead fluorescent lights in each room. -None of the overhead lights were operable independently. -The on/off switch could not be accessed by the residents while lying in bed. -Room #101 had three residents and 1 (accessible to the resident) bedside lamp, but the lamp did not work. -Room #102 had three residents and 1 bedside lamp (the lamp was approximately 8 inches tall and was accessible and working). -Room #103 had four residents and no bedside lamps. -Room #104 had four residents and no bedside lamps. Interview on 03/19/15 at 11:45 am with a resident who resided in room #103 revealed: -He would like to have a lamp at his bedside. -He had not requested a lamp from staff. Interview on 03/19/15 at 11:30 am with a resident who resided in Room #102 revealed: -He would like to have a lamp at his bedside. -He had considered buying a lamp for his room at a local thrift store. -He had not requested a lamp for his room from staff.	D 093		

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D 093	Continued From page 22 Interview on 03/19/15 at 1:30 pm with a resident who resided in Room #104 revealed: -She only had a small lamp that was 8 inches tall she had bought herself. -She liked to read and would like a bedside lamp if it was provided. -There were four people residing in one room, and sometimes she did not turn on the overhead lights because it disturbed her roommates. Interview on 03/19/15 at 1:40 pm with a resident who resided in Room #101 revealed: -He had a lamp "but I need another one because this one doesn't work." -Resident demonstrated that the light did not work. -He had not reported to staff that the lamp did not work. Interview on 03/19/15 at 1:45 pm with a resident who resided in Room #103 revealed: -There were no lamps in his room. -There were 4 residents residing in Room #103. -He enjoyed reading at night, but could not because turning the overhead light on disturbed his roommates. -He had not requested a lamp from staff. Refer to interview with a Personal Care Aide (PCA) on 03/19/15 at 2:30 pm. Refer to interview with the Resident Care Director (RCD) on 03/19/15 at 5:30 pm. Refer to interview with the Corporate Administrator on 03/20/15 at 3:00 pm. B. Observation during facility tour on 3/18/15 from 8:45 am to 9:45 am of Hall B (Rooms #105, #106, #107, #108, #109, and #110) revealed:	D 093		

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D 093	Continued From page 23 -Room #105 had three residents and no bedside lamps. -Room #106 had two residents and no bedside lamps. -Room #107 had two residents and no bedside lamps. -Room #108 had two residents and one bedside lamp. -Room #109 had three residents and no bedside lamp. -Room #110 had two residents and one bedside lamp. -An overhead ceiling light with the on/off switch was located left next to the entrance door of each room. -The on/off switch could not be accessed by the residents while lying in bed. Interview with a resident from one of the above mentioned rooms on 3/19/15 at 11:20 am revealed: -He had never had a bedside lamp. -His room mate has a bedside lamp. -He does not need one because of the lighting from the windows. -He had never requested a lamp to administration. Refer to interview with a Personal Care Aide (PCA) on 03/19/15 at 2:30 pm. Refer to interview with the Resident Care Director (RCD) on 03/19/15 at 5:30 pm. Refer to interview with the Corporate Administrator on 03/20/15 at 3:00 pm. _____ Interview with a PCA on 3/19/15 at 2:30 pm revealed:	D 093		

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D 093	Continued From page 24 -Since she began employment, did not recall bedside lamps in every room. -As far as she knew, residents had not complained about not having bedside lamps in their rooms. Interview on 03/19/15 at 5:30 pm with the RCD revealed: -She was previously employed at the facility and returned in September 2014 as the RCD. -She had received no requests from residents for bedside lamps. Interview on 03/20/15 at 3:00 pm with the Corporate Administrator revealed: -She was unaware that a bedside lamp was to be provided for each resident. -She had not received requests from residents for lamps in their rooms. -The facility had not purchased any lamps for residents' rooms since she had been Corporate Administrator for two years.	D 093		
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: Based on observations and interviews, the facility failed to assure the overhead fluorescent lights were working properly throughout the facility. (Halls A and B, dining area, and 10 out of 10 residents' rooms (Rooms #101, #102, #103, #104, #105, #106, #107, #108, #109, and #110).	D 105		

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D 105	Continued From page 25 The findings are: Observation during the initial tour on 3/18/15 and throughout the day on 3/19/15 revealed: - The facility had 27 fluorescent light fixtures (each constructed to contain 4 bulbs) recessed in the ceilings tiles of the hallways, dining area, and entrance foyer/sitting area. - Twenty-six of the 27 fluorescent lights in the ceiling were not working properly or were missing bulbs in the hallways (Hall A and Hall B), dining area, and entrance foyer/sitting area. - Residents' rooms had varying numbers of 4 bulb overhead fluorescent light fixtures not working properly or missing bulbs. A. Observation on 3/18/15 of the 4 bulb fluorescent light fixtures in dining hall area revealed two rows of 5 fixtures spaced about 4 feet apart beginning 6 feet from the entrance foyer wall, and a 4 bulb fixture located in an alcove within the dining room (containing 2 chairs and a television) with lighting as follows: - One row had one fixture with no bulbs burning, one fixture had all 4 bulbs burning and 3 fixtures had 2 of 4 bulbs burning. - The other row had 5 of 5 fixtures with 2 of 4 bulbs burning. - The fixture in the alcove had 2 of 4 lights burning. Refer to interview with Resident Care Director (RCD) on 3/19/15 at 10:57 am. Refer to interview with Maintenance Contractor on 3/19/15 at 11:00 am. Refer to Interview with Corporate Administrator on 3/19/15 at 2:40 pm.	D 105		

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D 105	Continued From page 26 B. Observation on 3/18/15 from 9:10 am to 10:45 am of the the 4 bulb fluorescent light fixture in the ceiling on the east end of Hall B revealed: - The light fixture was located directly above a chair and table with the residents' facility telephone located on the table. - The fixture only had 2 of 4 bulbs. - The light bulbs in the fixture were constantly flickering. Confidential interview with a resident revealed: - The resident had resided at the facility for about a year. - The flickering light in the fixture at the end of hall (above the telephone) had been flicking for almost a year. - The flickering gave the resident a headache. - The resident "wishes they would fix it." Interview on 3/19/15 at 2:30 pm with 2 residents in Room #109 (last room before the flickering light over the telephone) revealed: - The light fixture "does it all day" and all night if the lights were on. - The flickering bothered them at night unless the door was shut. - Staff sometimes turned the light off at night. - The bulbs had been flickering for at least a year. - The residents had told administration about the flickering bulbs months ago. Refer to interview with RCD on 3/19/15 at 10:57 am. Refer to interview with Maintenance Contractor on 3/19/15 at 11:00 am. Refer to Interview with Corporate Administrator on 3/19/15 at 2:40 pm.	D 105		

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D 105	Continued From page 27 C. Observation during facility tour on 3/18/15 from 8:45 am to 9:45 am of Hall B (Rooms #105, #106, #107, #108, #109, and #110) revealed: -Room #105 had 2 of 3 ceiling light fixtures not working properly. -Room #106 had 2 of 4 ceiling light fixtures not working properly. -Room #107 had 4 of 4 ceiling light fixtures not working properly, one of the light covers were cracked. -Room #108 had 2 of 3 ceiling light fixtures not working properly. -Room #109 had 2 of 5 ceiling light fixtures not working properly. -Room #110 had 2 of 4 ceiling light fixtures not working properly, with one of the light covers missing (the bulbs did have a protective sleeve to prevent shattering). -Hall B had 6 of 6 ceiling light fixtures not working properly. -Hall B had 1 of the 6 ceiling light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering). Interview with a resident from one of the above mentioned rooms on 3/19/15 at 11:20 am revealed: -The overhead lights had been that way for "a while now". -He had never reported it to the Administrator. Interview with a resident from one of the above mentioned rooms on 3/19/15 at 11:25 am revealed: -He had never paid attention to the ceiling light fixtures. -He had never reported it to the Administrator. Refer to interview with RCD on 3/19/15 at 10:57	D 105		

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D 105	Continued From page 28 am. Refer to interview with Maintenance Contractor on 3/19/15 at 11:00 am. Refer to Interview with Corporate Administrator on 3/19/15 at 2:40 pm. D. Observation during facility tour on 3/18/15 from 8:45 to 9:45 am of Hall B (Resident rooms #101, #102, #103, and #104) revealed: -Room #101 had 4 fluorescent light fixtures (each constructed to contain 4 bulbs) recessed in the ceiling for a total of 16 light bulb positions. -Fifteen of the 16 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #101. -Three residents resided in Room #101. -Room #102 had 4 fluorescent light fixtures (each constructed to contain 4 bulbs) recessed in the ceiling for a total of 16 light bulb positions. -Eight of the 16 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #102. -Room #102 had 2 of 4 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering). -Three residents resided in Room #102. -Room #103 had 6 fluorescent light fixtures (each constructed to contain bulbs) recessed in the ceiling for a total of 24 light bulb positions. -Sixteen of the 24 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #103. -Directly overhead at the entry door was a single light fixture which was on with a single halogen bulb without a cover on the fixture. -Four residents resided in Room #103. -Room #104 had 7 fluorescent light fixtures (each constructed to contain 4 bulbs) recessed in the	D 105		

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D 105	Continued From page 29	D 105		

ceiling for a total of 28 light bulb positions.
-Sixteen of the 28 fluorescent lights in the ceiling were not working properly or were missing bulbs in Room #104.
-Room #104 had 2 of 7 fluorescent light fixtures missing the cover (the bulbs did have a protective sleeve to prevent shattering).
-Four residents resided in Room #104.

Interview with a resident who resided in Room #103 on 3/19/15 at 11:30 am revealed:
-He would like to have more light in his room for reading.
-Some of the overhead lights had been missing bulbs or were burned out for "a long time."
-He had not requested that staff repair the overhead lights.

Interview with a resident who resided in Room #104 on 3/19/15 at 1:30 pm revealed:
-Her room was missing several overhead lights, but this did not bother her.
-She had not requested that staff repair the overhead lights.

Interview with a resident who resided in Room #101 on 3/19/15 at 11:45 am revealed:
-He had been a resident at the facility for two months.
-The light fixtures had been missing bulbs since he has been at the facility.
-He would like to have more light in his room.
-He had not requested that staff repair the overhead lights.

Refer to interview with RCD on 3/19/15 at 10:57 am.

Refer to interview with Maintenance Contractor on 3/19/15 at 11:00 am.

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D 105	Continued From page 30 Refer to Interview with Corporate Administrator on 3/19/15 at 2:40 pm. _____ Interview with Resident Care Director (RCD) on 3/19/15 at 10:57 am revealed: -She was previously employed at the facility and returned in September 2014 as the RCD. -The process for repairs was that the RCD informed the Corporate Administrator whom then informed the Maintenance Supervisor. -She was aware of the ceiling light fixtures repairs needed. -She had reported it to the Corporate Administrator in September 2014 and repairs began around that time. Interview with the Maintenance Contractor on 3/19/15 at 11:00 am revealed: -He had already replaced 10-12 ceiling light fixtures and had ordered other materials for the repairs. -He was in the process of painting every room. -His company came to see what needed to be repaired and they then ordered the materials and sent him to complete the repairs. Interview with Corporate Administrator on 3/19/15 at 2:40 pm revealed: -She was aware there were ceiling light fixtures not working properly and missing covers. -She had reported it to the Maintenance Supervisor but did indicate when. -She stated that the subcontracted maintenance staff had installed protective coverings for the bulbs in fixtures without covers to prevent shattering of the bulbs. -She stated that most of the ends holding the bulbs in place were broken and they had ordered	D 105		

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D 105	Continued From page 31 replacements. (No information for parts ordered or when ordered was available for review.)	D 105		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. The findings are: Review of Staff B personnel records revealed: -Staff B was hired on 2/11/15 as a Medication Aide. -Documentation of a completed HCPR check in Staff B's personnel record was dated 3/9/15 with no substantial findings. -Her daily responsibilities included passing medications to residents and performing care to the residents. Review of the facility staffing schedule revealed: -Staff B had worked ten shifts in 2/11/15-2/28/15. -Staff B had worked eight shifts in 3/1/15-3/9/15. Interview on 3/19/15 at 2:05 pm with Resident Care Director revealed:	D 137		

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D 137	Continued From page 32 -She was responsible for completing a HCPR check on each new employee. -She stated she had completed a HCPR check after the interview on January 31, 2015. -Staff B had initially declined the job offer and later changed her mind after she discarded the HCPR report away. -She did not realize it was missing until she did a employee file audit on March 9, 2015. -She completed the HCPR check on March 9, 2015 with no substantial findings. -Stated Staff B had been working on the floor since she started on 2/11/15. Telephone interview on 3/20/15 at 11:56 am with Staff B, Supervisor/medication aide revealed: - She had worked at the facility since 2/07/15 as a medication aide. - She routinely worked the night shift, and occasionally worked the evening shift. - She worked the evening shift with one personal care aide. - Administration processed her paperwork when she was hired. - She was not aware if all the forms had been completed.	D 137		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council,	D 167		

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D 167	Continued From page 33	D 167		

American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 1 of 19 days on third shift from 3/1/15-3/19/15, and for seven of twenty eight days on third shift from 2/1/15-2/28/15.

The findings are:

A. Review of Staff B's personnel file revealed:
-Staff B was hired as a Medication Aide on 2/9/15.
-No documentation of CPR training.

Review of the staff work schedule (3/1/15-3/19/15) for Staff B revealed:
-Staff B worked third shift (3/16/15) with a Personal Care Aide (PCA), whom was not CPR certified.

Review of the staff work schedule (2/1/15-2/28/15) for Staff B revealed:
-Staff B worked with a PCA, whom was not CPR certified on third shift on the following dates:
-2/12/15, 2/15/15, 2/16/15, 2/17/15, 2/19/15, 2/22/15 and 2/26/15.

Interview with Resident Care Director (RCD) on

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D 167	Continued From page 34 3/19/15 at 4:00 pm revealed: -She thought Staff B had CPR training from previous employer. -She thought she had a copy of Staff B's CPR card in the personnel file. -The RCD was told by Staff B that her CPR expired in 2014, but did not get a copy of the card from Staff B's previous employer. -The facility sent staff to a CPR class on 11/14/14 and 3/13/15. Telephone interview on 3/20/15 at 11:56 am with Staff B, Supervisor/Medication Aide revealed: - She did not provide the facility a copy of a current CPR/choking certification when she filled out employment information. - She had worked at the facility since 2/07/15 as a medication aide. - She routinely worked the night shift, and occasionally worked the evening shift. - She worked the evening shift with one personal care aide. - She had not had a CPR recertification since coming to the facility. - She had a CPR training at a previous facility but was not able to locate documentation for the expiration of her training, but she thought it was November 2014. - No resident had been required CPR or had an incident for choking during a shift she had worked at the facility. The facility provided a Plan of Protection on 3/19/15 as follows: - Immediately the Resident Care Coordinator (RCD) rearranged the schedule to assure at least one staff with a current CPR was working. - The RCD will make sure at least one staff member one each shift had current CPR when making the schedule.	D 167		

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D 167	Continued From page 35 - The RCD will have all staff CPR certified and will offer classes on various days to make sure all staff attend. - The RCD will have CPR certification in the files and available. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 4, 2015.	D 167		
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 observation, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulation related to staff training on cardio-pulmonary resuscitation requirements and physical environment related to chemicals not stored in a locked area when not in use and not monitored by staff. The findings are: A. Based on record reviews and interviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 1 of 19 days on third shift from 3/1/15-3/19/15, and for seven of twenty eight	D912		

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D912	Continued From page 36 days on third shift from 2/1/15-2/28/15. [Refer to Tag 0167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation).] B. Based on observation and interviews, the facility failed to assure cleaning agents used by 2 residents (Resident #4 and #5) were stored in a separate locked area when not in use and monitored by staff and were stored in a resident's room (Room #102) which could be hazardous if ingested or inhaled. [Refer to Tag 0056, 10A NCAC 13F .0305(f)(4) Physical Environment (Type B Violation).]	D912		