

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL081051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/20/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NANAS ASSISTED LIVING FACILITY # 2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2270 OAKLAND ROAD FOREST CITY, NC 28043</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments  The Adult Care Licensure Section and the Rutherford County DSS conducted a complaint investigation on-site on May 18 and 19, 2016 with a telephone exit on May 20, 2016.	D 000		
D 074	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the walls, floors and ceilings for 17 of 27 resident rooms, the living room walls, and the kitchen and food storage areas were kept clean and in good repair.</p> <p>The findings are:</p> <p>A. Observation of the resident rooms on the men's hall during initial tour on 5/18/16 from 9:30am to 1:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Room #17: The ceiling fan had dusty blades and the window sills were dusty.</li> <li>-Room #19: The overhead light pull was very short and difficult to reach and there was no light bulb in the globe, there was a heavy coat of dust was on the ceiling vent, and the window sills were dusty.</li> <li>Room #20: There was a heavy coat of dust on the ceiling vent, window sills were dusty, the door handle was loose on the bathroom door, a corner of a tile in the bathroom floor was broken off exposing the floor underneath and the bathroom</li> </ul>	D 074		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 074	<p>Continued From page 1</p> <p>tiles had dark rusty stains.</p> <p>-Room #23: A heavy coat of dust was on the ceiling vent, the window sills were dusty, cob webs were on the ceiling, and there was no cover for the overhead bathroom light.</p> <p>-Room #25: A heavy dust was on the ceiling vent, cobwebs were on the wall around the closet and behind the room door and above headboard of bed, the window sills were dusty, and there was no cover on the the overhead bathroom light exposing bulb.</p> <p>-Room #26: There was a heavy coat of dust on the overhead vent, dust was on the ceiling fan, there was no cover for the overhead light, and the metal plate for the overhead light socket was missing.</p> <p>-Room #27: A thick dust covered the right lower section of the louvered closet door and the bottom of the bathroom door frame was rusted off and missing.</p> <p>-Room #28: A heavy coat of dust was on the ceiling vent, a black circle of dust was on the ceiling around the ceiling fan, the ceiling fan was very dusty, cob webs were on the ceiling, the window sills were dusty, a towel rack in the bathroom was unsecured on one side and taped to the wall on the other side, and there was no cover on the bathroom light.</p> <p>-Room #27: There was no door knob on the closet door.</p> <p>-There were no unoccupied resident rooms on the men's hall.</p> <p>Interview with Staff A, PCA, on 5/18/16 at 11:45am revealed:</p> <p>-She was a personal care aide but started doing housekeeping "last week."</p> <p>-The housekeeper quit recently.</p> <p>-She had been using a broom to sweep the floors and was not aware the facility had a vacuum</p>	D 074		

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D 074	<p>Continued From page 2</p> <p>cleaner. -She had not been instructed to clean the ceiling vents or the window sills.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -She did a "walk though" on Monday this week [5/16/16] to check for maintenance items and cleanliness. -She had not seen any missing light covers or anything that needed cleaning or repairing. -They did have a vacuum cleaner that could be used for cleaning the vents and window sills.</p> <p>-Confidential interviews with 8 residents residing on the men's hall revealed no concern related to the cleanliness or of their rooms.</p> <p>B. Observations of the women's hall during the initial facility tour on 5/18/16 from 9:30am to 12:00pm revealed: -Resident Room #1 the ceiling vent was hanging down loose from the ceiling approximately a 1/2 inch on one side of the vent. -Resident Room #3 the paint was chipped and peeling for an approximate 1 inch area bordering the ceiling vent. -Resident Room #4 the ceiling vent was hanging down loose from the ceiling approximately a 1/2 inch on one length of the vent. -Resident Room #6 there were seven dime sized areas of damage to the wall (1/4 inch indentions with missing paint) at the head of the bed closest to the windows. -Resident Room #7 the ceiling vent was hanging down loose from the ceiling approximately a 1/4 inch on one side of the vent. -Resident Room #10 the ceiling vent was coated in a thick layer of dust. -Resident Room #12 the ceiling vent was coated</p>	D 074		

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D 074	<p>Continued From page 3</p> <p>in a thick layer of dust.</p> <p>-Resident Room #13 the ceiling vent was hanging down loose from the ceiling approximately a 1/4 inch on one side of the vent.</p> <p>-Resident Room #14 the ceiling vent was coated in a thick layer of dust.</p> <p>-Resident Room #16 the ceiling vent was coated in a thick layer of dust.</p> <p>-The shared bathroom between Resident Room #14 and #16 (both unoccupied) was missing a handle on the door leading into Resident Room #14.</p> <p>-In the living room there was an area of black discoloration of the white paint on the ceiling and wall on either side of the fireplace that was approximately 16 feet in length and 2 feet wide or more in some places.</p> <p>-The main hallway door leading down the women's hall had black streaks and chipped paint for the bottom 2 feet of the door.</p> <p>Interview with the Manager on 5/19/16 at 11:10am revealed:</p> <p>-She was unaware the ceiling vents were loose and dusty in some of the resident rooms on the women's hall.</p> <p>-The Personal Care Aides (PCA) "are supposed to report issues like these when they see them."</p> <p>-Maintenance was in the facility "when we call and let them know we need something fixed. Only takes them an hour or so to get here to fix things."</p> <p>Interview with a PCA revealed "Usually if I see something that don't look right, I let the management know."</p> <p>Interview with Staff A, PCA, on 5/18/16 at 11:45am revealed:</p> <p>-She was a personal care aide but started doing</p>	D 074		

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D 074	<p>Continued From page 4</p> <p>housekeeping "last week." -She had been using a broom to sweep the floors and was not aware the facility had a vacuum cleaner. -She had not been instructed to clean the ceiling vents or the window sills.</p> <p>Interview with the Regional Manager on 5/19/16 at 2:35pm revealed: -She would talk with Maintenance and see if the ceiling vents "will tighten up" and if not buy new screws to put in the vent frame. -Maintenance was usually in the building four days a week, Monday through Thursday.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -She did a "walk though" on Monday this week [5/16/16] to check for maintenance items and cleanliness. -She had not seen any missing light covers or anything that needed cleaning or repairing. -They did have a vacuum cleaner that could be used for cleaning the vents and window sills. -They had a maintenance form that the facility manager supposed to fill out and give to her is there were any maintenance needs.</p> <p>Confidential interviews with five residents who resided on the women's hall revealed no one had any complaints about the condition of the ceiling vents or walls in their rooms.</p> <p>C. Observation of the kitchen walls and floors on 5/19/16 at 1:55pm revealed: -Tile under and around the dish machine and stove had dark rust stains. -Wall behind the dish machine area was unpainted with areas which appeared to have had paint scraped off.</p>	D 074		

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D 074	<p>Continued From page 5</p> <p>-Heavily stained cement floor in the dry storage area.</p> <p>Review of the current Health and Sanitation Report, dated 12/7/15 revealed:</p> <p>-"Repair the wall behind the dish machine to make it smooth and easily cleanable.</p> <p>-"Repair the floor under the stove.</p> <p>-"Clean the floors and walls in the back two rooms."</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed:</p> <p>-She had contacted a man to fix the floors and walls in the kitchen but he developed physical problems and had been delayed in fixing the areas.</p> <p>-She expected him to come any day to repair the floors and walls.</p> <p>-They had a maintenance form that the facility manager supposed to fill out and give to her is there were any maintenance needs.</p> <p>D. Observation of the facility living room on 5/18/16 at 3:15pm revealed the walls were dingy gray and in need of painting.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed she was aware the living room needed to be painted.</p>	D 074		
D 076	<p>10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(3) have furniture clean and in good repair;</p> <p>This Rule shall apply to new and existing</p>	D 076		

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D 076	<p>Continued From page 6</p> <p>facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have all furniture clean and in good repair in 7 of 22 resident rooms.</p> <p>The findings are:</p> <p>A. Observation of the resident rooms on the men's hall during initial tour on 5/18/16 from 9:30am to 1:00pm revealed: -Resident room #22: The bedside table drawer was open and the right side of the drawer was lower than the left side. -Resident Room #17: One of the two pulls was missing on the top drawer and both pulls were missing on the middle drawer of a three drawer dresser.</p> <p>Interview with the Facility Manager on 5/18/16 at 2:30pm revealed: -The family member of the resident who resided in Room #22 would be there that evening to take the resident out of the facility. -Staff would clean the side table and room while the resident was out of the facility because the resident did not want anyone cleaning while he was in the room. -The side table belonged to the resident and the family member would bring in another one since the drawer was not functioning properly.</p> <p>Refer to interview with the Facility Manager on 5/19/16 at 11:10am.</p> <p>Refer to interview with the Regional Manager on 5/18/16 at 2:35pm.</p> <p>Refer to interview with a Personal Care Aide</p>	D 076		

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D 076	<p>Continued From page 7</p> <p>(PCA).</p> <p>Refer to interview with a second PCA.</p> <p>Refer to the local county health and sanitation report, dated 3/7/16.</p> <p>B. Observations during the initial facility tour on 5/18/16 from 9:30am to 12:00pm on the women's hall revealed:</p> <ul style="list-style-type: none"> <li>-Resident Room #6: There were missing and inadequate pulls on 3 drawers of the resident dresser.</li> <li>-Resident Room #10: There were 3 missing pulls and 1 loose pull on the nightstand on the left side of the room and 2 missing pulls from the nightstand on the right side of the room. There was one pull missing from the bottom left drawer of the resident's dresser.</li> <li>-Resident Room #12: There were 3 pulls missing from the top right drawer of the dresser.</li> <li>-Resident Room #13: There were 2 pulls missing and 1 pull which was hanging loose on the bottom 2 drawers of the dresser.</li> <li>-Resident Room #14: There were 8 pulls missing from the dresser.</li> </ul> <p>Confidential interviews with five residents who lived on the women's hall revealed:</p> <ul style="list-style-type: none"> <li>-4 of 5 residents had no complaints about the missing pulls from the furniture.</li> <li>-One resident stated "that bottom drawer is really hard to open" because the pull on the drawer was hard to hold onto.</li> </ul> <p>Refer to interview with the Facility Manager on 5/19/16 at 11:10am.</p> <p>Refer to interview with the Regional Manager on 5/18/16 at 2:35pm.</p>	D 076		



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D 076	<p>Continued From page 8</p> <p>Refer to interview with a PCA.</p> <p>Refer to interview with a second PCA.</p> <p>Refer to the local county health and sanitation report, dated 3/7/16.</p> <p>_____</p> <p>Interview with the Facility Manager on 5/19/16 at 11:10am revealed: -She was unaware there were pulls missing from some of the furniture in resident rooms on the women's hall. -The Personal Care Aides (PCA) "are supposed to report issues like these when they seem them." -Maintenance was in the facility "when we call and let them know we need something fixed. Only takes them an hour or so to get here to fix things."</p> <p>Interview with a PCA revealed "Usually if I see something that don't look right, I let the management know."</p> <p>Interview with a second PCA revealed "I had noticed some [furniture pulls] were missing. I have reported it" to management.</p> <p>Interview with the Regional Manager on 5/18/16 at 2:35pm revealed, "I think the last survey we went to the [local hardware store name] and put on a lot of new pulls while y'all were here at the end of last year."</p> <p>Review of the current local county health and sanitation report, dated 3/7/16 revealed, "Must continue to discard and replace damaged furniture, ....The furnishings must be maintained in good repair."</p>	D 076		

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D 079	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure the home was maintained clean and free of all obstructions and hazards in resident rooms as related to pest spray in resident rooms, closet doors off the track, a nail protruding from a box spring, use of extension cords, two unsecured toilet seats, exposed lamp sockets, a protruding outlet cover, protruding metal plate on the front entrance door, no carbon monoxide detector for the gas logs in the living room, and areas that were not clean.</p> <p>The findings are:</p> <p>A. Observation of resident rooms during the initial tour on 5/18/16 from 9:30am to 1:00pm revealed two cans of bug spray in 2 resident rooms. -Two cans of bug spray in the closet of Resident Room #27. -Two cans of bug spray in a basket on the floor beside the dresser in Resident Room #22.</p>	D 079		

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D 079	<p>Continued From page 10</p> <p>Interview with the resident residing in Room #22 on 5/18/16 at 10:45am revealed: -The bug spray was donated by a church group. -He was not aware of any pests in the facility which required bug spray.</p> <p>Based on diagnoses of the Resident who resided in Room #27, an interview was determined to be unsuccessful.</p> <p>Interview with the Facility Manager on 5/18/16 at 12:00pm revealed: -She was not aware any residents had bug spray in their rooms. -She would remove the bug spray from the resident rooms.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -She did a "walk through" on Monday this week [5/16/16] to check for maintenance items and cleanliness. -She did not see any bug spray in resident rooms.</p> <p>Interview with Staff A, who was doing housekeeping on 5/18/16, revealed: -She was a personal care aide but started doing housekeeping "last week." -She had not observed any bug spray in resident rooms.</p> <p>B. Observation during the initial tour on 5/18/16 from 9:30am to 1:00pm revealed: -In Resident Room #10 there were two extension cords plugged together with one end plugged into an electrical outlet. The two extension cords were run from the outlet around the top of the door frame leading into the bathroom and was left hanging loose on the left side of the door frame. There were three Velcro straps affixed to the wall</p>	D 079		

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D 079	<p>Continued From page 11</p> <p>which were securing the extension cords around the door frame.</p> <p>-In Resident Room #11 there was an extension cord plugged into an outlet and to a radio sitting on the resident's bedside table.</p> <p>-In Resident Room #27, an extension cord was plugged into an electrical outlet and the other end plugged into the cord for the resident's coffee pot.</p> <p>Interview with the Facility Manager on 5/18/16 at 12:00pm revealed she was not aware of any extension cords in resident rooms.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed:</p> <p>-She did a "walk through" on Monday this week [5/16/16] to check for maintenance items and cleanliness.</p> <p>-She did not see any extension cords.</p> <p>Interview with Staff A, who was doing housekeeping on 5/18/16, revealed:</p> <p>-She was a personal care aide but started doing housekeeping "last week."</p> <p>-She had not observed any extension cords in resident rooms.</p> <p>C. Observation of the mattress and bed box springs in resident rooms on initial tour on 5/18/16 from 9:30am to 1:00pm revealed three residents' mattresses or box springs as follows:</p> <p>- Resident Room 2: A nail was protruding out of the box springs at least 1/2 inch on the front side of the bed.</p> <p>- Resident Room 19: On the first bed in the room, the box springs was not resting on the bed rails but was hanging below the bed rail and gave way when sat on.</p> <p>-Resident Room #5: The resident's bed was</p>	D 079		

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NAME OF PROVIDER OR SUPPLIER  <b>NANAS ASSISTED LIVING FACILITY # 2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2270 OAKLAND ROAD FOREST CITY, NC 28043</b>
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D 079	<p>Continued From page 12</p> <p>comprised of a twin size boxsprings with a hospital bed mattress placed on top of the boxsprings. The hospital mattress was too big for the boxsprings and hung over the boxsprings at the bottom of the bed unsupported for approximately 6 inches.</p> <p>Interview with the resident who resided in Room #5 on 5/18/16 at 9:50am revealed; -The mattress "don't bother me, but I would like to be able to sit on the edge of the bed." -The resident demonstrated when he tried to sit on the bottom edge of the bed it was unstable and "it wasn't safe to sit on the edge."</p> <p>Interview with the Regional Manager on 5/19/16 at 2:35pm revealed: -She was aware of the situation of the hospital mattress being too big to fit correctly over the boxsprings for the bed in Room #5. -She had moved the hospital mattress out of the room before, but the resident who lived in the room had went and gotten the mattress and put it back on the bed. -She would get a twin size mattress and put it in on the bed again.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -She did a "walk through" on Monday this week [5/16/16] to check for maintenance items and cleanliness. -She did not see the nail in the box springs. -She was not aware of the mattress which was too big for the box springs. -They had a maintenance form the facility manager supposed to fill out and give to her if there were any maintenance needs.</p> <p>D. Observation in the living room on 5/18/16 at</p>	D 079		

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D 079	<p>Continued From page 13</p> <p>12:09pm and 1:49pm revealed: -There was a bent metal outlet cover on a post which had sharp protruding edges. -There was a 4 inch by 8 inch piece of metal nailed on one side to the bottom left door frame of the front entrance door. The metal had sharp protruding edges.</p> <p>Observation in the living room on 5/19/16 at 9:00am revealed the metal outlet cover on the post had been replaced.</p> <p>Interview with Regional Manager on 5/19/16 at 10:50am revealed she had replaced the bent electrical outlet the evening of 5/18/16.</p> <p>E. Observation of resident rooms during the initial tour on 5/18/16 from 9:30am to 1:00pm revealed sliding closet doors off the hinges in the following rooms: -Room #17: both closet doors off track -Room #19: right closet door off track -Room #21: right closet door off track -Room #22: right closet door off track -Room #19: right closet door off track</p> <p>Interview with the resident residing in Room #21 on 5/18/16 at 10:45am revealed: -"The closet door will fall on you, it is dangerous, I am scared to touch it." -The maintenance man always says he will fix it.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -She did a "walk through" on Monday this week [5/16/16] to check for maintenance items and cleanliness. -All the closet doors were on track on "Monday." -They had a maintenance form that the facility manager supposed to fill out and give to her if</p>	D 079		

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D 079	<p>Continued From page 14</p> <p>there were any maintenance needs. -No one had informed her of the doors off track or any issues.</p> <p>F. Observation of the living room on 5/18/16 at 1:00pm revealed a fireplace with unvented gas logs and no carbon monoxide detector available in the living room.</p> <p>Interview with the Regional Facility Manager on 5/19/16 at 2:45pm revealed they had a carbon monoxide detector in the living room during the winter but placed it in a closet when they no longer needed the fireplace for the spring/summer.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -They could not find a carbon monoxide detector in the facility. -She would purchase one today, 5/20/16, and place it in the living room.</p> <p>G. Observation of the bathroom adjoining Resident Rooms #5 and #7 on 5/18/16 at 9:53am revealed the commode lid was completely off the commode and propped between the commode and the wall on the right side.</p> <p>Interview with a resident which used the bathroom adjoining Resident Rooms #5 and #6 revealed: -He had to put the seat onto the commode before he could use it. -He had to be "careful" when he sat on it, because the seat was not secured. -He was the only one that used that bathroom. -The seat had been broken on the commode since the last week of December 2015. -He had reported it to staff and 'they said it cost</p>	D 079		

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D 079	<p>Continued From page 15</p> <p>too much money to fix it."</p> <p>Observation of the bathroom adjoining Resident Rooms #9 and #11 on 5/18/16 at 11:20am revealed the seat was completely off the commode and sitting in the floor beside the commode.</p> <p>Inteview with a resident which used the bathroom adjoining Resident Room #9 and #11 on 5/18/16 at 11:20am revealed: -The toilet seat had "been pulled off." -The resident who lived in the other adjoining room had "pulled it off." -The commode lid had been that way for "2 months." -He had reported it was broken to staff and they told him they would get it fixed. -"Just to have a toilet seat that works. To go in use the toilet... It would be nice."</p> <p>Interview with the Facility Manager on 5/19/16 at 11:10am revealed: -She was not aware the toilet seats were not connected in the shared bathroom between Resident Rooms #5 and #7 and #9 and #11. -"The residents haven't said anything about it." -"We have extra toilet seats here in stock." -"I will get that taken care of today."</p> <p>Interview with a Personal Care Aide (PCA) on 5/19/16 at 11:52am revealed: -The resident who used the bathroom adjoining Resident Room #5 had never reported anything to her about the commode seat being broken. -She was unaware the commode seat was broken in the bathroom adjoining Resident Rooms #9 and #11.</p> <p>Interview with a second PCA on 5/19/16 at</p>	D 079		



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D 079	<p>Continued From page 16</p> <p>12:47pm revealed: -The commode seat in the bathroom adjoining Resident Room #5 had been broken "not long at all...less than a week." -"Today I just took it completely off because it was leaning." -She was unaware the commode seat was off the commode in the bathroom adjoining Resident Room #9 and #11 or how long it had been that way.</p> <p>Interview with the Regional Manager on 5/19/16 at 2:35pm revealed: -"I didn't know the seats were off." -"We made a walk through [of the facility] this past Monday and [the toilet seats] were not off."</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed she did a "walk though" on Monday this week [5/16/16] to check for maintenance items and cleanliness.</p> <p>H. Observation of resident rooms during the initial tour on 5/18/16 from 9:30am to 1:00pm revealed light bulbs missing from the lamps over resident beds exposing the open sockets as follows: -Resident Room #4: There was no light bulb in the socket of the lamp over the bed and the lamp was plugged into a receptacle. -Resident Room #9: There was no light bulb in the socket of the lamp over the bed and the lamp was plugged into a receptacle. -Resident Room #10: There was no light bulb in the socket of the lamp over the bed and the lamp was plugged into a receptacle. -Resident Room #14: There was no light bulb in the socket of the lamp over the bed and the lamp was plugged into a receptacle. -Resident Room #16: There was no light bulb in</p>	D 079		

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D 079	<p>Continued From page 17</p> <p>the socket of the lamp over the bed and the lamp was plugged into a receptacle. The overhead light was also missing a light bulb leaving the socket exposed.</p> <p>-Resident Room #28: There was no light bulb in the lamp over the bed and the lamp was plugged into a socket.</p> <p>Interview with the Facility Manager on 5/19/16 at 11:10am revealed:</p> <p>-She was not aware there were missing bulbs from several over bed lamps in the resident rooms,</p> <p>-The Personal Care Aides (PCA) "are supposed to report issues like these when they see them."</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed she did a "walk though" on Monday this week [5/16/16] to check for maintenance items and cleanliness and did not see any missing bulbs.</p> <p>I. Observation of resident rooms during the initial tour on 5/18/16 from 9:30am to 1:00pm revealed the following areas that needed cleaning:</p> <p>-In the common bathroom on the women's hall, the sink was heavily coated in gray soap scum all over the inside of the sink basin and there was heavy rust stains down the side of the sink under the faucet.</p> <p>-In the common bathroom on the women's hall, there were gray soap scum and orange rust stains all over the sides and bottom of the tub.</p> <p>-In the bathroom adjoining Resident Room #9 and #11 on 5/18/16 at 11:23am revealed the sink was coated in pink and gray soap scum all over the inside of the sink basin.</p> <p>-In the bathroom of Resident Room #20, the sink had a scum residue inside the sink.</p>	D 079		

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D 079	<p>Continued From page 18</p> <p>Interview with the Facility Manager on 5/18/16 at 12:00pm revealed: -The housekeeper they did have quit recently, "walked out," but was not sure of the date. -They have plans to hire someone for housekeeping and laundry, but currently they have personal care aides they are bringing in to do housekeeping and laundry.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed she did a "walk through" on Monday this week [5/16/16] to check for maintenance items and cleanliness.</p> <p>Confidential interviews with 16 residents on 5/18/16 revealed: -16 of 16 residents had no complaints about the housekeeping. -One resident stated "We have good housekeeping staff now. They keep it really clean." -A second resident stated staff "clean everyday and different people do housekeeping." -A third resident's room was cleaned "everyday" by staff. -A fourth resident stated staff emptied the trash from her room "2 to 3 times a day." -A fifth resident stated that sometimes he cleans his room and sometimes staff clean the room.</p> <hr/> <p>The Plan of Protection provided by the facility on 5/18/16 revealed: -The facility will assure all areas are in compliance with the rule. -All rooms will be observed to see if any immediate threats to residents. -The facility manager will conduct routine monitoring and train staff how to monitor for hazardous situations in the rooms.</p>	D 079		

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D 079	Continued From page 19  -Maintenance will be called to fix and hazards.  An addendum to the Plan of Protection was provided by the facility on 5/20/16 which revealed the facility will purchase a carbon monoxide detector and place it in the living room today, 5/20/16.  _____  CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 4, 2016.	D 079		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; 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 all residents had a readily accessible supply of pillows, pillow cases, and clean towels on hand for use at all times.  The findings are:  A. Observation of the resident rooms during initial tour on 5/18/16 from 9:30am to 1:00pm revealed the following beds did not have pillowcases on the pillows. -Room #17: no pillow case on the pillow of the bed near the window.	D 080		

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D 080	<p>Continued From page 20</p> <p>-Room #23: no pillowcase on the bed near the door.</p> <p>-Room #24: no pillowcase on the pillow of the bed near the door.</p> <p>-Room #20: no pillow on the bed near the door and no pillow case on the pillow on the bed near the window.</p> <p>-Room #28: no pillowcases on two pillows on the bed near the bedroom door.</p> <p>Interview with the resident who resided in room #20 on 5/18/16 at 11:15am and slept on the bed near the door on 5/18/16 at 11:10am revealed he wanted a pillow with a pillowcase and did not know why he did not have one.</p> <p>Interview with the resident who resided in room #23 on 5/18/16 at 10:30am revealed he wanted a pillowcase for his pillow.</p> <p>Interview with a Personal Care Aide who was doing housekeeping on 5/18/16 at 11:15am revealed she did not know why residents did not have pillowcases on their pillows.</p> <p>B. Observation of the men's hall and women's hall during initial tour on 5/18/16 from 9:30am to 1:00pm revealed none of the residents had bath towels or wash clothes available in their bathrooms.</p> <p>1. Observation of the men's hall during initial tour on 5/18/16 from 9:30am to 1:00pm revealed:</p> <p>-The shared bathroom between Resident Room #26 and #28 did not have any towels or washcloths available for the residents that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Room #25 and #27 did not have any towels or</p>	D 080		

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D 080	<p>Continued From page 21</p> <p>washcloths available for the residents that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Room #22 and #24 did not have any towels or washcloths available for the residents that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Room #21 and #23 did not have any towels or washcloths available for the residents that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Room #17 and #19 did not have any towels or washcloths available for the residents that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Room #18 and #20 did not have any towels or washcloths available for the residents that routinely used the bathroom. Paper towels were available.</p> <p>2. Observations of the women's hall during the initial facility tour on 5/18/16 from 9:30am to 12:00pm revealed:</p> <p>-The shared bathroom between Resident Rooms #1 and #3 did not have any towels or washcloths available for the residents that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Rooms #5 and #7 had one towel, but no washcloths available for the resident that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Room #6 and #8 did not have towels or washcloths available for the two residents that routinely used the bathroom. Paper towels were available.</p> <p>-The shared bathroom between Resident Room</p>	D 080		

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D 080	<p>Continued From page 22</p> <p>#9 and #11 did not have towels or washcloths available for the two residents that routinely used the bathroom. Paper towels were available.</p> <p>Confidential interviews with four residents on 5/18/16 revealed:                      -"When I need to take a shower they don't have enough washcloths."                      -When asked if there were enough towels and washcloths available for staff to give the resident a shower the resident replied "I don't think so. I don't know why."                      -A third resident stated towels and washcloths were available but "I have to ask for one [towel and washcloth] to get one. If I forget, I just have to air dry before putting my clothes on."                      -"They have towels on the shelf in the [common shower room on the men's hall] bathroom. Also have some in the linen closet. They don't mind you asking."                      -"They moved the girl from laundry to up here on the floor, so I don't know whose doing it now."</p> <p>Interview with the Facility Manager on 5/18/16 at 10:56am revealed:                      -Staff handed out a towel and washcloth to each resident when it was time for their shower.                      -Residents were showered three times a week.                      -"Everyone here gets assistance with their showers."                      -"Whoever is assigned to that shower that day brings the towels and washcloths."                      -"We leave some out in the shower room, so they can get them when they need them."                      -"I lost the key this am. I have called [maintenance staff's name] to come and fix it. He's supposed to be coming to fix it. I think I locked the key in there."</p> <p>Observation of the main linen storage closet</p>	D 080		

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D 080	<p>Continued From page 23</p> <p>beside the main dining room on 5/18/16 at 10:56am revealed the door was locked and could not be accessed.</p> <p>Observation of the men's hall common shower room linen storage area on 5/18/16 at 11:01am revealed 4 bath towels and 1 washcloth were available on the shelf.</p> <p>Observation of the main linen storage closet beside the main dining room on 5/18/16 at 2:05pm revealed there were no towels or washcloths in the closet only bed linens.</p> <p>Observation in the storage area outside the Facility Manager's office on 5/18/16 at 2:06pm revealed there were 6 bath towels, 15 cotton washcloths, and 12 microfiber cloths available.</p> <p>Interview with the Facility Manager on 5/18/16 at 2:06pm revealed "We have more towels and washcloths down to be laundered."</p> <p>Interview with one Personal Care Aide (PCA) on 5/19/16 at 12:20pm revealed there were enough washcloths and towels available to do resident showers.</p> <p>Interview with a second PCA on 5/19/16 at 12:47pm revealed there were enough washcloths and towels available to do resident showers.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -Staff had not informed her they needed towels and washcloths for the residents. -It was the Personal Care Aides (PCAs) responsibility to make sure all residents had towels and washcloths and let management know if they needed supplies.</p>	D 080		



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D 080	Continued From page 24  -They had two common showers/bathrooms and she thought there were towels in those rooms. -She would instruct the PCAs to put bath towels and washcloths in the resident bath rooms.	D 080		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; 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 4 of 22 resident room windows and 2 of 14 bathroom windows had privacy coverings, functional privacy coverings, or privacy curtains in good repair.  The findings are: Observations during the the initial facility tour on 5/18/16 from 9:30am to 12:00pm of the resident's rooms revealed: -There was no window covering on the ground level bathroom window of the bathroom adjoining Resident Room #2 and #4. -Resident Room #6 there was a four inch piece of missing slat from the blind covering the right ground level window. There was no window covering on the ground level bathroom window of the bathroom adjoining room #6 and #8. -Resident Room #9 there were two blinds hanging over the windows, however the plastic slides used to hold the blinds into the frames	D 083		

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D 083	<p>Continued From page 25</p> <p>were missing and when the blinds were touched to be adjusted the entire blind assembly would fall out of the frame. The blinds were covering a ground level window facing the parking lot at the front of the building.</p> <p>-There was a towel being used to cover the window in the shared bathroom adjoining Room #9 and Room #11.</p> <p>-Resident Room #14 there were two blinds hanging over the windows, however two plastic slides used to hold the blinds into the frames were missing and when an attempt was made to adjust the blinds one side of the assembly would fall out of the frame.</p> <p>-Resident Room #25, one of two windows had no covering. The blind was on the floor under the window.</p> <p>Interview with the Manager on 5/19/16 at 11:10am revealed:</p> <p>-She was unaware some of the blinds in the resident rooms on the women's hall were missing, damaged, or were missing plastic retaining pieces so the blinds could not be adjusted safely.</p> <p>-The Personal Care Aides (PCA) "are supposed to report issues like these when they seem them."</p> <p>-Maintenance was in the facility "when we call and let them know we need something fixed. Only takes them an hour or so to get here to fix things."</p> <p>Interview with a PCA revealed "Usually if I see something that don't look right, I let the management know."</p> <p>Interview with the Regional Manager on 5/19/16 at 2:35pm revealed:</p> <p>-"We just got all new blinds in January of this year. I know when we put them up they had tabs</p>	D 083		

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D 083	Continued From page 26  in them." -"We walk around once a week" to check the facility for maintenance issues. -"I did not notice before yesterday that some were missing and I got some last night to replace them." -Maintenance was usually in the building four days a week, Monday through Thursday.  Confidential interviews with 5 residents revealed: -4 of 5 residents interviewed revealed no concerns with the blinds or window coverings. -"Its been a little difficult to let the blinds down. I always keep my blinds up even at night." -The blinds in Resident Room #9 have been "that way" for 5 to 7 months.	D 083		
D 087	10A NCAC 13F .0306(b)(1) 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: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing	D 087		

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D 087	<p>Continued From page 27</p> <p>facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all mattresses and box springs were in good repair in 5 of 22 occupied resident rooms.</p> <p>The findings are:</p> <p>A. Observation in Resident Room #5 on 5/18/16 at 9:50am revealed: -The resident's bed was comprised of a twin size boxsprings with a hospital bed mattress placed on top of the boxsprings. -The hospital mattress was too big for the boxsprings and hung over the boxsprings at the bottom of the bed unsupported for approximately 6 inches.</p> <p>Interview with the resident who resided in Room #5 on 5/18/16 at 9:50am revealed; -The mattress "don't bother me, but I would like to be able to sit on the edge of the bed." -The resident demonstrated when he tried to sit on the bottom edge of the bed it was unstable and "it wasn't safe to sit on the edge."</p> <p>Interview with the Regional Manager on 5/19/16 at 2:35pm revealed: -She was aware the hospital mattress was too big for the boxsprings for the bed in Room #5. -She had moved the hospital mattress out of the room before, but the resident who lived in the room had went and gotten the mattress and put it back on the bed. -She would get a twin size mattress and put it in the room again.</p> <p>Refer to the current local county health and</p>	D 087		

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D 087	<p>Continued From page 28</p> <p>sanitation report dated 3/17/16.</p> <p>Refer to interview with the Administrator on 5/20/16 at 10:30am.</p> <p>B. Interview with the resident on 5/18/16 at 9:45am who resided in Room 28 revealed: -He wanted a board to go between the mattress and box springs something from the box springs pressed on him like a "puncture" and caused a "knot" on his back. -He had asked the facility manager for a board but no one had responded to his request.</p> <p>Interview with the Regional Manager on 5/18/16 at 9:55am revealed: -They had "just ordered" 26 box springs and mattresses for this facility. -She was not aware the resident residing in Room #28 had asked for a board to go between his mattress and box springs.</p> <p>Refer to the current local county health and sanitation report, dated 3/17/16.</p> <p>Refer to interview with the Administrator on 5/20/16 at 10:30am.</p> <p>C. Observation of the box springs in Resident Room #19, on the first bed of the room, the box springs was not resting on the bed rails but was hanging below the bed rail and gave way when sat on.</p> <p>Interview with the Resident who slept in the first bed in Resident Room #19 on 5/19/16 at 11:15am was not successful because he was out of the facility.</p> <p>Refer to the current local county health and</p>	D 087		

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D 087	<p>Continued From page 29</p> <p>sanitation report, dated 3/17/16.</p> <p>Refer to interview with the Administrator on 5/20/16 at 10:30am.</p> <p>D. Observation of the bed box springs in Resident Room #25 revealed a nail protruding out of the box springs at least 1/2 inch on the front side of the bed.</p> <p>Interview with the Regional Manager on 5/18/16 at 9:55am revealed: -They had "just ordered" 26 box springs and mattresses for this facility. -She was not aware of the nail on the box springs in Resident Room #25.</p> <p>Refer to the current local county health and sanitation report, dated 3/17/16.</p> <p>Refer to interview with the Administrator on 5/20/16 at 10:30am.</p> <p>E. Observation of the mattress on the first bed in Resident Room #28 revealed a hole at least 3 inches long in the mattress.</p> <p>Interview with the resident residing in Room #28 on 5/18/16 at 9:30am revealed he did not know how long the hole had been in the mattress and did not know what caused it.</p> <p>Refer to the current local county health and sanitation report, dated 3/17/16.</p> <p>Refer to interview with the Administrator on 5/20/16 at 10:30am.</p> <p>_____</p> <p>Review of the current local county health and</p>	D 087		

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D 087	Continued From page 30  sanitation report, dated 3/7/16 revealed, "Must continue to discard and replace damaged furniture, mattresses, and box springs. The furnishings must be maintained in good repair."  Telephone interview with the Administrator on 5/20/16 at 10:30am revealed: -They had already ordered some new mattress. -She was not aware of any specific problems related to the mattresses.	D 087		
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 each resident had a functioning light or lamp over their bed within reach or failed to have light bulbs in the lamps for 9 of 27 resident rooms.  The findings are:  Observation of the resident rooms during initial tour on 5/18/16 from 9:30am to 1:00pm revealed 6 resident lamps with no bulbs (Rooms #4, #9, #10, #14, #16, and #28) and the following:	D 093		

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D 093	<p>Continued From page 31</p> <p>Observation of Resident Room #23, on 5/18/16 at 10:25am revealed: -The lamp above the first bed would not work and there was no outlet available to plug in the lamp. -The 2 plug outlet near the first bed had two electrical cords already in use by the resident residing in the first bed.</p> <p>Observation of Resident Room #7 (occupied) on 5/18/16 at 10:45am revealed: -There were two residents living in the room. -There was no lamp available to the resident in the bed on the left side of the room. -The roommate had a bedside lamp.</p> <p>Interview with a resident who resided in Resident Room #7 on 5/18/16 at 10:25am revealed he would like to have a functioning lamp.</p> <p>Observation of Resident Room #6 on 5/18/16 at 10:10am revealed: -There was no lamp available to the resident in the bed on the left side of the room. -The roommate had a bedside lamp. -There was no overhead light fixture on the ceiling fan and there was no other overhead light fixture installed.</p> <p>Interview on 5/18/16 at 10:10am with the resident who did not have a bedside lamp revealed: -"I asked them [about a lamp] but I don't know what they are gonna do about it." -She liked the overhead fan and did not want an overhead light fixture installed.</p> <p>Telephone interview with the Administrator on 5/20/16 at 10:30am revealed she was not aware of any issues with the residents lamps or missing bulbs.</p>	D 093		



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D912	Continued From page 32	D912		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings.</p> <p>The findings are:</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure the home was maintained clean and free of all obstructions and hazards in resident rooms as related to pest spray in resident rooms, closet doors off the track, a nail protruding from a box spring, use of extension cords, two unsecured toilet seats, exposed lamp sockets, a protruding outlet cover, protruding metal plate on the front entrance door, no carbon monoxide detector for the gas logs in the living room, and areas that were not clean. [Refer to Tag 79 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation).]</p>	D912		