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D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services conducted an annual and follow-up survey and complaint investigation on July 13-15, 2016 and July 18, 2016. The complaint investigation was initiated by the Rutherford County Department of Social Services on May 4, 2016.	D 000		
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 observations, interviews, and record reviews, the facility failed to assure the walls, floors and ceilings for #1, #17, #20, and #24 resident rooms, the living room walls, and the kitchen and food storage areas were kept clean and in good repair. The findings are: A. Observations during the initial facility tour on 7/13/16 from 9:00am to 11:30am revealed: -In Resident Room #1, the ceiling vent was hanging down loose from the ceiling approximately an inch on one side of the vent. -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. Telephone interview with the Administrator on	D 074		

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D 074	Continued From page 1 7/18/16 at 2:40pm revealed their painters had been painting their other facility and "have not gotten to it yet." Confidential interviews with four residents during the initial facility tour revealed no one had any complaints about the ceilings or walls in the facility. B. Observation of the kitchen walls and floors on 7/14/16 at 10:51am revealed: -Tile under and around the dish washer and stove had dark rust stains. -Wall behind the dish machine area was unpainted with areas which appeared to have had paint scraped off. -Heavily stained rusty color at least 3 feet in diameter on cement floor in the dry storage area. Review of the current Health and Sanitation Report, dated 12/7/15 revealed: -"Repair the wall behind the dish machine to make it smooth and easily cleanable. -"Repair the floor under the stove. -"Clean the floors and walls in the back two rooms." Telephone interview with the Administrator on 7/18/16 at 2:40pm revealed: -Their painters had been painting their other facility and "have not gotten to it yet." -They planned to repair the tile. C. Observation of Room #17 on 7/13/16 at 10:43am revealed: -There was a puddle of water at least 12 inches by 18 inches on the left side of the room in front of the sink. -There was a dry spot between the commode and the puddle of water.	D 074		

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D 074	Continued From page 2 Interview with one of the residents who resided in Room #17 on 7/13/16 at 10:43am revealed -The commode leaked when flushed. -It had been that way for "one month." Interview with the Regional Manager on 7/13/16 at 11:34 revealed a resident who resided in the room urinates in the floor. Observation of the bathroom in Room #17 on 7/14/16 at 10:46am revealed there was a puddle of water 12 inches by 18 inches on the left side of the bathroom. Observation of bathroom in Room #17 on 7/15/16 at 1:25pm revealed there was a puddle of water 12 inches by 18 inches on the left side of the bathroom. Observation of the bathroom in Room #17 on 7/18/16 at 9:30am revealed there was a puddle of water 12 inches by 18 inches on the left side of the bathroom. Interview with the Resident Care Coordinator on 7/18/16 at 9:30am revealed: -The Resident who resided in Room #17 washed his face "all the time" by turning the water on and splashing it on his face. -They cleaned the area daily. D. Observation of Room #20 on 7/13/16 at 10:38am revealed: -A bathroom tile in front of the door had a triangle shaped piece at least 3 inches in diameter broken off exposing the floor underneath. -Other tiles in front of the commode and on the left side of the commode had 6 brown rusty stained which were all at least 6 inches wide by 4	D 074		

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D 074	Continued From page 3 inches wide Telephone interview with the Administrator on 7/18/16 at 2:40pm revealed they planned to repair the tile. E. Observation of Room #24 on 7/13/16 at 9:32am revealed the screen on the left window was was torn away from the frame leaving an open area at least 12 inches by 4 inches, but the window was closed. Telephone interview with the Administrator on 7/18/16 at 2:40pm revealed she was not aware of the torn screen, but they would repair it.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure the home was maintained clean and free of all obstructions and	D 079		

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hazards as related to resident rooms with bed bugs, two unsecured toilet seats, a mattress hanging over boxsprings, box springs hanging below the bed rail, unsecured window blinds, closet doors off track and inoperable, exposed light sockets, an extension cord, and facility areas that were not clean.

The findings are:

A. Confidential interview with a resident during the initial tour on 7/13/16 revealed:
-She had seen red places on the exposed skin of Resident #10's arms and legs, which she believed to be caused by bug bites.
-"One day I saw [a bug] in front of her on the floor. It was black."

Interview with Regional Manager and Resident Care Coordinator on 7/14/16 at 10:15am revealed:
-A local pest control company had been contacted on 7/12/16 to check the facility and make sure that there were no bed bugs.
-They said that the pest control provider came and sprayed for bed bugs just in case there were some.
-Both staff stated that they were not aware of bed bugs in the facility and that the pest control company simply sprayed as a precaution.

Interview with the Regional Manager on 7/15/16 at 8:19am revealed:
-Somebody had donated 12 bags of clothes to the residents in the facility.
-Staff had distributed the clothes by size to various residents throughout the facility.
-One of the staff had said they had found "a little bug" in one of the bags.
-As soon as the staff had told her about the bug,

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"I came and got the clothes and threw them away" which occurred on 6/28/16.
-She then notified a local pest control service that staff had found "a little bug" in one of the donated bags.
-The local pest control service came out and identified bed bugs in Rooms #6, #8, #9, #10, #11, #12, #13, #14, #15, #17, #18, #20, #21, #25, and #28 and they did a "pretreatment" in those rooms.
-She had not informed the county health inspector that bed bugs had been identified in the facility in multiple occupied resident rooms.
-She had the facility physician's assistant to assess 15 residents' skin. Some were assessed 6/30/16 and the others on 7/8/16.
-Some rashes were identified on residents, but the physician's assistant had called the rash "chigger bites" and did not think they were caused by bed bugs.
-Staff were informed bed bugs had been identified in the facility and precautions to take after working in the facility.
-Visitors to the facility had been told not to bring anything into the facility and to take off their clothes when they go home and wash them.
-The local pest control treatment was supposed to begin heat treatments on the rooms identified to have bed bugs on 7/25/16.

Interview with pest control company on 7/14/16 at 10:58am revealed:
-The pest control provider came out to the facility on 6/30/16 and "found a few bed bugs in several rooms."
-The pest control provider came back out to the facility on 7/12/16 and and found bed bugs in 15 resident rooms: Rooms #6, # 8, #9, #10, #11 #12, #14, #13, #15, #17, #18, #20, #21 #25 and #28.
-The pest control provider stated that of those 15

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rooms, some had one or two bed bugs, while others had a "few."
-The pest control provider finalized a contract with the facility on 7/1/16 to return on 7/25, 7/26, 7/27, and 7/28/16 with heat machines.
-The provider plans to treat 4 rooms a day on the before mentioned dates.
-The devices seal the room and heat the temperature to above 135 degrees for a 3 hour period in order to terminate the bed bugs.
-The provider also sprayed the base boards and bed frames in resident rooms on 7/12/16.

Interview with Regional Manager and Resident Care Coordinator on 7/14/16 at 11:15am revealed that they didn't know that there was an infestation of bed buds in the facility but did know that the heat treatment was to occur at the end of the month, but thought that it was just to make sure there were no bed bugs.

Observation on the men's hallway on 7/18/16 from 8:20am to 8:30am revealed no bed bug traps had been applied to the legs of the residents beds in Rooms #17, #18, #20, #21, #25, and #28, which were identified to have bed bugs by the pest control company.

Interview with the Regional Manager on 7/18/16 at 8:45am revealed:
-They had not been able to find bed bug traps to put on the beds on 7/15/16, so that had not put any traps on the beds after they had cleaned them.
-Staff had cleaned all the rooms identified with bed bugs over the weekend, however they would reclean all the bed frames, headboards, wipe the mattress covers down, pull the beds out from the walls, and apply clean linens to the beds after applying bed bug traps to the legs of the beds in

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the affected rooms.
-"We have found a place to buy traps."
-The Resident Care Coordinator had gone to buy the bed bug traps.

Confidential interviews with two residents who lived in rooms identified to have bed bugs on 7/18/16 revealed the following comments:
-"They sprayed my bed, but it didn't work."
-"Those bugs jumped on me again last night."
-Staff had worked in his room all day on Saturday 7/16/16, "but the bugs got on me again all night last night."
-"I think they worked in some other rooms Saturday."
-"Something's eating me alive. I have to take Benadryl for it."
-"A man came last week and sprayed my bed and under my bed. Sprayed between the wall and the floor. He said there shouldn't be anything biting me anymore."
-"It's bad to lay at night itching and scratching."
-The bugs had been in one resident's bed for "I know two weeks now."

Confidential interview with a Personal Care Aide revealed no one had informed staff there were bed bugs in multiple resident rooms in the facility and precautions to take for the residents or themselves.

Confidential interview with a visitor to the facility revealed the facility staff had not communicated to them bed bugs had been identified in multiple resident rooms and the precautions to take to protect themselves.

1. Review of Resident #10's current FL2 dated 6/9/16 revealed diagnoses of psychosis, hypertension, and osteoarthritis.

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D 079	Continued From page 8 Review of Resident #10's record revealed no physician visit related to skin rash. Observation of Resident's #10 Room #6, and non occupied bed in same room, found no evidence of infestation. Interview with Resident #10 on 7/13/16 at 9:50am revealed: -She was not sure what the rash was on her legs. -"My doctor doesn't know either." -"I'm supposed to see a skin doctor this Friday." -"I also have places on the back of my neck, my back, and my arms." -The rash started "last week." -The resident had seen "some bugs" on the floor of her room "last Thursday." -She stated that she had seen and killed 3 "little black bugs" on her legs a few days prior. -She stated that the "little black bugs bite and itch." Observation of Resident #10 sitting on a couch in the living room on 7/13/16 at 9:45am revealed scattered red spots on the resident's exposed skin on both legs from the mid-shin to the ankles. 2. Review of Resident #9's current FL2 dated 4/5/16 revealed diagnoses of asthma, hypertension, bi-polar, and schizophrenia. Review of Resident #9's record had no documentation of medical care of any skin rash. Interview with Resident #9 on 7/14/16 at 2:30pm revealed: -Resident complained that he had a rash on his lower back above the pants line from something in his bed.	D 079		

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-Stated that he has "little bugs in the bed at night that are black."
-Resident stated that this has been an issue for at least "the past few weeks. "
-Resident stated that "It has been hard to sleep due to the biting and scratching."

Observation of Resident #9's back on 7/14/16 at 2:30pm with facility staff present revealed scattered red spots on the entire lower back.

Observation of Resident #9's bed in Room #28 revealed two small dark red bugs and what appeared to be dried blood smears on both the sheet and pillow case.

3. Review of Resident #8 current FL2, dated 3/9/16, revealed diagnoses of legally blind and hypertension..

Review of Resident #8's record revealed a physician visit dated 7/8/16 as follows:
-Documentation for treatment of "itchy rash. "
-Treatment included hydrocortisone 1% cream with aloe on affected areas as needed (used to treat redness and itching).

Interview with Resident #8 on 7/15/16 at 9:05am revealed:
-He had been to the doctor for a rash.
-Stated that he has "bites from little black bugs in the bed that cause me to itch and bleed." and cause "blood smears in the bed" when he mashes them.
-Resident stated that this has been "going on for the past 2 or 3 weeks."

-Observation of Resident #8's bed in Room #20 revealed:
-The plastic cover had one small, one medium,

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and one large dark red bug.
-The bed sheets had multiple spots that appeared to be dried blood smears.

4. Review of Resident#7 current FL2 dated 3/10/16 revealed diagnoses of mental retardation, schizophrenia, and diabetes.

Review of Resident #7's record revealed his primary care physician treated him for "pruritic rash" and "mild erythema" on 7/7/16 and prescribed hydrocortisone cream 2.5% (used to treat redness and itching) on affected areas twice daily, skin check in one week, and keep scheduled routine follow up.

Observation of Resident #7 on 7/15/16 at 9:40am revealed he appeared to have scattered red spots on the entirety of both arms and neck.

Interview with Resident #7 on 7/15/16 at 9:40am revealed:
-Resident stated "has little bugs in the bed that make me itch and bleed."
-Resident stated this "this been going on for about a month."
-Resident stated that he "went to the doctor because of the itching and they gave me a cream."

Observation of Resident #7's bed in Room #17 revealed one large dark red bug and what appeared to be dried blood smears on the resident's sheets.

B. Observation of the bathroom adjoining Resident Rooms #5 and #7 on 7/13/16 at 10:32am revealed the toilet seat was not secured at the back.

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Interview with a resident who used the bathroom adjoining Resident Rooms #5 and #7 revealed "They still haven't fixed the toilet seat."

Observation of the bathroom adjoining Resident Rooms #9 and #11 on 7/13/16 at 11:00am revealed the toilet seat was missing off the commode.

Interview with a resident who used the bathroom adjoining Resident Room #9 and #11 on 7/13/16 at 11:00am revealed:
-The facility had "not yet" fixed the toilet seat.
-"Its been off for awhile."

Interview with Maintenance on 7/13/16 at 12:56pm revealed:
-He had replaced the toilet seats in the shared bathrooms adjoining Room #5 and #9 before "but if the residents sit on the lids real hard they break" the securing hardware at the back of the toilet seats.
-"A clip is all that's missing" from the toilet lid in the bathroom adjoining Room #5.
-He was repairing both toilet seats now.
-He had repaired both toilet seats after the 5/20/16 survey, "If it was on the list I fixed it."

C. Observation's made during the initial tour on 7/13/16 at 10:32am in occupied Resident Room #5 revealed:
-The resident's bed was comprised of 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.

Interview with the Regional Manager on 7/14/16

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D 079	Continued From page 12 at 4:30pm revealed: -They had put a new mattress that fit properly on the boxsprings in Room #9 after the last survey. -However, the resident did not like the new mattress and had them put the hospital bed mattress back in his room. Interview with the resident who lived in the room on 7/14/16 at 4:32pm revealed the facility had never gotten him a replacement mattress. Observation's of Room #19 on 7/13/16 at 10:47am, on the first bed in the room revealed the box springs were not resting on the bed rails, but were hanging below the bed rail and gave way when sat on. Interview with the Regional Manager on 7/14/16 at 4:30pm revealed she was not aware the box springs in Room #19 had not been fixed. D. Observation during the initial tour on 7/13/16 at 11:00am in occupied Resident Room #9 revealed: -There were no plastic retaining clips to secure the residents blinds into the frames. -When the string was pulled to adjust the blinds, the blinds would fall out of the frames. Interview with the resident who lived in the room on 7/13/16 at 11:00am revealed: -"I don't use the blinds much, but they haven't been changed yet." -"I hadn't seen anybody come by to fix" the blinds. Interview with the Regional Manager on 7/14/16 at 4:30pm revealed: -They had fixed all the blinds after the 5/20/16 survey. -She did not know how the blinds in Room #9 had	D 079		

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NANAS ASSISTED LIVING FACILITY # 2	2270 OAKLAND ROAD FOREST CITY, NC 28043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 13 been missed, but they would get them fixed. E. Observation of closet doors in resident rooms during the initial tour on 7/13/16 from 9:00am to 12:00 noon. -Room #17: Sliding closet doors off track. -Room #19: Sliding closet doors off track and not operable. -Room #20: Sliding left closet door off track -Room #21: Sliding right and left closet door off track, half way open, and not operable. -Room #22: Sliding left closet door off track -Room #27: No door handle on hinged closet door. Interview with the resident who resided in Room #17 on 7/15/16 at 8:53am revealed: -They are "really hard to open." -"I have to work with it to open; never works." Interview with the other resident who resided in Room #17 on 7/15/2016 at 8:53am revealed: -The closet doors are "always broken." -"I haven't been in it in sometime." Interview with one resident who resided in Room #20 on 7/15/16 at 8:44am revealed: -The closet doors are "hard to open." -He has to "get someone to help" him open the doors. -The doors "jump off track." Interview with the other resident who resided in Room #20 on 7/15/16 at 8:40am revealed: -He has to pull "really hard" to get the closet door open. -He "always has an issue" with the doors. -Sometimes the door comes off the tracks. Based on observation and record review of the	D 079		

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D 079	Continued From page 14 Resident who resided in Room #27, an interview was determined to be unsuccessful. Telephone interview with the Administrator on 7/18/16 at 2:40pm revealed she would work on a "permanent fix for the closet doors." F. Observation during the initial tour on 7/13/16 from 9:00am to 12:00 noon revealed: -In Room #27, the overhead light bulb in the ceiling fan was exposed with no cover. -In Room #28, the overhead light bulb in the ceiling fax was exposed with no cover. -In Room #17, the overhead light bulb was exposed with no cover and the light did not work when turned on. Interview with the Regional Manager on 7/13/16 at 11:15am revealed: -They purchased light covers for all the rooms which needed one. -A maintenance staff was supposed to put them up but he had an illness in the family and had to leave about "two weeks ago." Observation of Rooms #17, #19, #27, and #28 on 7/18/16 from 9:15am to 9:35am revealed all the light covers had been installed and all the lights were operable. G. Observation during the initial tour on 7/13/16 at 9:20am in Room #27 revealed an extension cord was plugged into an electrical outlet and the other end plugged into the cord for the resident's coffee pot. Interview with the Regional Manager on 7/13/16 at 11:20am revealed: -She had placed a surge protector in Room #27 for the coffee pot.	D 079		

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D 079	Continued From page 15 -She just found out the resident who resided in the room sold it to another resident. Based on observation and record review of the resident who resided in Room #27, an interview was determined to be unsuccessful. Observation of the other resident's room on 7/15/16 at 1:15pm revealed there was a surge protector plugged into his television. Observation of Room #27 on 7/18/16 at 9:15am revealed the coffee pot was not plugged into an extension cord or outlet. H. Observation of the living room on 7/13/16 at 2:35pm revealed: -A bird cage on a table in the corner with a live bird inside. -The bottom of the bird cage was very dirty with seed shells and bird excrement. -There were seed shells on the outside of the cage on the table top. -The bird water container was dirty. Observation of the bird cage on 7/15/16 at 8:30am revealed the bird cage had not been cleaned. Confidential interview with a personal care aide on 7/15/16 at 8:30am revealed she did not know who was responsible for cleaning the bird cage. Interview with the Regional Manager on 7/15/16 at 10:35am revealed: -Resident #11 was in charge of taking care of the bird cage. -Resident #11 liked to sleep late and had not gotten out of bed yet to feed the bird and clean the cage.	D 079		

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D 079	Continued From page 16 Interview with Resident #11 on 7/15/16 at 1:15pm revealed: -She was not able to "take care of the bird and clean the bird cage." -She would not mind if the facility found another home for the bird. Interview with the Resident Care Coordinator on 7/18/16 at 9:30am revealed she would take care of the bird and be responsible for cleaning the cage. I. Observation on the front porch of the facility on 7/15/16 at 8:00am revealed: -A trash can sitting in the right corner of the porch. -Trash was piled 1 ft. over the top of the can and spilling out onto the floor. -On the outside of the right side of the porch there were numerous loose empty aluminum cans lying in a pile next to the side of the building. Telephone interview with the Administrator on 7/18/16 at 2:40pm revealed they had housekeeping staff 7 days per week for 6 hours per day. A plan of protection was provided by the facility on 7/15/16 and 7/18/16 as follows: -A pest control service has been contacted. -Headboards and bedrails will be cleaned with pure pinesol. -Beds will be moved away from walls and repositioned along with night stands. -Will clean floors and walls. -Administrator has purchased mattress and boxspring encasements with zippers. Duct tape will be placed at zipper.	D 079		

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D 079	Continued From page 17 -All residents will be checked every 2 days to make sure everybody's skin is okay and it will be documented on a nurses note by the Medication Aide. -A physician will come to the facility every week to help with skin assessments. -Administrator furnished material to make bed bug traps for legs of beds. -We will have a staff training to let all staff know how they need to protect themselves as well as residents and their families. -Contacted to local health department to report bed bugs. -Will repair closet doors and replace blinds in room #9. THE FACILITY GAVE A CORRECTION DATE FOR THE UNBATED TYPE B VIOLATION OF JULY 29, 2016.	D 079		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure personal care was provided for three of five residents sampled (Residents #1, #2, and #3) who required assistance with nail care.	D 269		

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D 269	Continued From page 18 The findings are: A. Review of current FL2 for Resident #1 dated 4/5/16 revealed: -Diagnoses included diabetes mellitus. -Resident #1 was designated as non-ambulatory with a wheelchair. -No orders for routine fingerstick blood sugars. Review of the care plan, dated 4/4/16, revealed Resident #1 was total care in bathing, dressing, grooming, and transferring. Review of the current Care Plan dated 4/4/16 revealed no documentation related to nail care and "normal" was checked under skin care. Review of Resident #1's two most current Licensed Health Professional (LHPS) reports, dated 2/10/16 and 5/16/16, revealed no assessment or recommendations related to Resident #1's nails. Interview with Resident #1 on 7/14/16 at 9:00am revealed: -He had asked the Resident Care Coordinator (RCC) and the Regional Manager to get an appointment to get his fingernails and toenails trimmed within the past month. -He said his toenails were long and growing sideways. -He said he had "never" refused for his nails to be trimmed, but stated, "They refused me." Observation of Resident #1's hands and feet on 7/14/16 at 9:32am with Staff F, Personal Care Aide, present revealed: -On the resident's left hand, all 5 fingernails were yellowed and growing downward 1/4" over the	D 269		

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end of the flesh of the fingertips.
-On the resident's right hand, all 5 fingernails were thickened, yellowed, growning downward 1/4" over the end of the flesh of the fingertips, with black debris visible under the tips of the fingernails.
-On the resident's right foot, the great toenail was thickened, yellow, rough, curved, and growing 1/2" from the end of the flesh of the toe.
-The 2nd, 3rd, and 4th toenails on the resident's right foot were yellowed, rough, and growing 1/4" from the end of the flesh of the toe.
-The 5th toenail on the resident's right foot was 1/4" long, growing downward into the flesh of the toe.
-On the resident's left foot, the great toenail was thickened, yellow, jagged, rough, and growing 1/4" from the end of the flesh of the toe.
-The 2nd and 4th toenails on the resident's left foot were thickened, yellowed, and growing 1/4" from the end of the flesh of the toes.

Review of Resident #1's resident record revealed no contract for Podiatry Services and no documentation of any attempts to obtain nail care.

Review of Resident #1's resident record revealed he had received medical services at a veteran's hospital on 5/31/16 and was scheduled for a return visit.

Interview with a nurse at the veteran's hospital on 7/13/16 at 3:18pm revealed they provided podiatry services but they had no record that staff had called to request any podiatry services for Resident #1.

Review of the primary care physician visits for Resident #1 revealed a nurse practioner or a

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physician's assistant who worked at the primary physician office saw him on 1/28/16, 2/11/16, 2/25/16, 3/4/16, and 7/7/16 with no documentation of the condition of his nails or that Resident #1 refused nail care.

Interview with the Regional Manager on 7/15/16 at 10:07am revealed:
-She knew Resident #1's nails were long, but he always refused nail care.
-Their staff could not trim his nails because Resident #1 was a diabetic.
-The primary care physician sent them a fax on 7/14/16 with a statement of the refusals.
-She was not aware of any appointments they had scheduled in the past or the future for Resident #1 to get his nails trimmed.

Review of the primary care physician's statement, dated 7/14/15, revealed:
-Resident #1 "has been refusing nail care for several months."
-The statement was signed by a physician, not the nurse practioner or the physician assistant who saw Resident #1 on the visits listed above.

Telephone interview on 7/14/16 at 11:41am with the Nurse who completed the LHPS reviews on 2/10/16 and 5/16/16 revealed she had not assessed Resident #1's nails on those dates because he was no longer receiving routine fingerstick blood sugar checks.

Telephone interview with the Administrator on 7/18/16 at 2:40pm revealed she did not know what their policy was if a resident refused health care or nail care, that she would have to look it up.

Confidential interviews with two personal care

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aides during the survey revealed they had informed the RCC and the Regional Manager that Resident #1 needed nail care.

B. Review of the current FL2 for Resident #2 dated 6/9/16 revealed diagnoses included diabetes mellitus.

Review of Resident #2's Care Plan dated 4/4/16, revealed Resident #2 required total care in bathing, dressing, and grooming with no documentaion of condition of toenails or fingernails.

Observation of Resident #2's hands and feet on 7/14/16 at 9:45am with Staff F, Personal Care Aide, present revealed:
-On the resident's right hand, the thumb nail, 1st finger, 4th finger, and 5th finger nails were rough with black debris underneath and growing 1/4" over the end of the flesh of the fingertips.
-On the resident's left hand, all the nails were rough with black debris underneath and growing 1/4" over the end of the flesh of the fingertips.
-On the resident's right foot, the 2nd and 3rd toenails were curved under the toe 1/4" long and growing into the flesh of the toes.

Interview with Resident #2 on 7/14/16 at 9:45am revealed:
-"Someone took me to the doctor last week and they cut my toenails, but they didn't cut my fingernails. I need my fingernails clipped."
-He said he had asked the Regional Manager and the Resident Care Coordinator to get his fingernails trimmed.

Review of the Resident #2's Podiatry visit for 6/21/16 revealed:

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D 269	Continued From page 22 -Toenail care with debridement. -No documentation of Resident #2's fingernails. Review of Resident #2's record revealed no documentation of attempts to schedule him an appointment for fingernail care. Review of the current LHPS review, dated 5/16/16, revealed nails were assessed to be "WNL" (within normal limits). Telephone interview with the Administrator on 7/18/16 at 2:40pm revealed she thought the podiatrist was supposed to cut Resident #2's toenails and finger nails and she did not know why they had not. C. Review of Resident #3's current FL2 dated 3/24/16 revealed: -Diagnosis of dementia -The resident was documented as incontinent of bladder and bowel and requiring personal care assistance with bathing and dressing. Review of Resident #3's Resident Register revealed the resident was admitted on 3/24/16. Review of Resident #3's Care Plan dated 3/24/16 revealed the resident was independent with all activities of daily living. Review of Resident #3's Plan of Care/Comprehensive Assessment Update completed by Hospice dated 7/12/16 revealed: -The resident began receiving care from Hospice on 7/7/16. -The resident was documented to require total assistance with bathing, dressing, toileting, and transfers. -The resident was documented to require	D 269		

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D 269	Continued From page 23 moderate assistance with eating. Observation of Resident #3's feet on 7/14/16 at 10:54am with Staff F, Personal Care Aide, present revealed: -On the resident's right foot, the great toenail was thickened, yellow, rough, curved, with black debris, and growing 1/2" from the end of the flesh of the toe. -The 2nd toenail on the resident's right foot was growing 1/8" from the end of the flesh of the toe. -The 3rd, and 5th toenails on the resident's right foot were thickened, yellow, with black debris underneath the nails, and growing 1/4" over the end of the flesh of the toe. -The 4th toenail on the resident's right foot was growing 1/2" outward from the flesh of the toe, yellowed, thick and curved. -On the resident's left foot, the great toenail was thickened, yellow, rough, curved, and growing 1/2" from the end of the flesh of the toe. -The 2nd, 3rd, and 4th toenails were thickened, yellow, rough, and growing 1/4" over the end of the flesh of the toes. Review of Resident #3's record revealed no documentation of a podiatry visit since his admission on 3/24/16. Interview with the Resident Care Coordinator (RCC) on 7/14/16 at 11:00am revealed: -Resident #3 was "up and doing everything for himself until last week. He is now on Hospice." -Resident #3 had experienced a rapid decline in his ability to perform activities of daily living due to recent cancer diagnosis. -Resident #3 was not a diabetic, so staff were allowed to cut his nails. -She would contact Hospice and see if they would cut his nails.	D 269		

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D 269	Continued From page 24 Interview with a Personal Care Aide (PCA) on 7/14/16 at 11:45am revealed: -She routinely showered Resident #3. -Resident #3 had gone to the doctor "last week and they were supposed to look at his toenails." -She had reported Resident #3's long toenails to the Medication Aide the night before the resident's doctor's appointment the next day. Telephone interview with the Administrator on 7/18/16 at 2:15pm revealed: -The PCA's were responsible for resident nail care during showers or between 2pm and 3pm the PCA's go around and check the resident's nails. -The Regional Manager makes podiatry appointments for resident's who need them every 2 to 3 months. Based on record review and observation of Resident #3 on 7/14/16, the resident was determined not to be interviewable.	D 269		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident.	D 287		

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D 287	Continued From page 25 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the table service included a non-disposable place setting consisting of a knife, fork, and spoon. The findings are: Review of the census revealed 31 residents on 7/13/16. Observation of the noon meal on 7/13/16 before the residents came into the dining room revealed the place setting consisted of a plastic spoon for each of the residents. Observation of the non-disposable flatware supply on hand in the kitchen on 7/13/16 at 12:15pm revealed they had a supply of 14 forks, 4 table knives, and no teaspoons. Observation on 7/13/16 at 12:15pm of the dish drainer where dishes had been washed and air dried revealed at least 15 plastic spoons in the drainer. Interview with the one dietary staff on duty on 7/13/16 at 12:15 revealed: -She did not usually cook but was filling in for another staff. -She said she was just doing as she was told by another staff but would not say who. -She did not know why they washed plastic spoons. -She did not know there no more non-disposable flatware available. Interview with the Regional Manager on 7/13/16 at 12:20pm revealed: -Staff had gone to get some non-disposable	D 287		

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flatware to have for the noon meal.
-The Resident Care Coordinator (RCC) was in charge of food service and she did not know why they had set the table with only plastic spoons.
-She knew that a lot of residents would carry out the flatware with them.

Observation of the meal served for the lunch meal on 7/13/16 between 12:15pm and 1:00pm revealed:
-The plastic spoons had been removed from the dining room table by 12:20pm with no flatware on the tables.
-Residents were served their meal on a tray with a non-disposable fork except for 3 residents who were given a plastic spoon.
-Residents were served meat loaf, mashed potatoes, green beans, sweet potatoes, bread, tea, and water.
-None of the residents were observed to have any problems using the plastic spoon.

Observation of the noon meal on 7/14/16 at 12:00 noon revealed:
-Residents were served baked chicken,
-The only flatware on the table setting was a non-disposable fork for each resident.
-None of the residents were observed to have any problems using the non-disposable fork.

Interview with the RCC on 7/18/16 at 1:30pm revealed:
-They used plastic spoons on 7/13/16, because they had a picnic the day before and just used the ones leftover from the picnic.
-There was a relief staff cooking on 7/13/16, not the regular staff.
-She was not aware they supposed to set the table with a fork, knife, and spoon.
-Some residents preferred to use a plastic spoon

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D 287	Continued From page 27 and they made sure they had one. -They always helped the residents cut up their food if they needed it, but most of the time the food was tender and the residents did not need a knife. -She would make sure the facility had a sufficient supply of flatware on hand for the residents. Interview with the Cook on 7/15/16 at 2:15pm revealed: -He routinely worked in the kitchen as cook. -He was not aware they supposed were to give the residents a fork, knife, and spoon. -If residents asked for a knife they would give them one. Confidential interviews with eight residents during the survey revealed: -Six of the residents had no concerns with the disposable or non disposable flatware they had been using. -One resident said she brought her own plastic spoon to the dining room with her and preferred the spoon. -One resident said they give them plastic spoons to eat with about two times per week, "It's hard to eat a pork chop with a plastic spoon." Telphone interview with the Administrator on 7/13/16 at 2:40pm revealed: -She was not aware they were using plastic spoons. -They were supposed to use non-disposable flatware. -She did not know the supply of non-disposable flatware was low.	D 287		
D 317	10A NCAC 13F .0905 (d) Activities Program	D 317		

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D 317	Continued From page 28 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide a minimum of 14 hours of planned group activities per week that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and the learning of new skills. The findings are: Interview with the Facility Manager on 7/13/16 at 9:00am revealed the facility census was 31. Interview with five residents during the initial tour on 7/13/16 from 9:00am until 11:30am revealed the following comments concerning activities: -When asked are activities offered, one resident stated "Not too often." -"We watch movies and play bingo and stuff." -"We haven't had any activities in awhile. So long I can't remember. We used to play bingo and we	D 317		

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D 317	Continued From page 29	D 317		

would bowl."
-"They have activities for anyone that wants to do one...books, puzzles, and magazines."
-A preacher comes on Thursdays at 10am.
-The Regional Manager will play the piano for us sometimes.
-"We have movies once in awhile. We watched 'Winn Dixie'," the movie, recently.
-"We play bingo sometimes, but not lately."
-"We don't have any," activities just "smoke and sit outside."
-Another resident said they do not offer any activities, but they would "like some."

Observation on 7/13/16 at 10:30am revealed the Regional Manager was playing the piano and singing for the residents in the living room.

Observation on 7/14/16 at 10:30am revealed a large group of residents were gathered in the living room listening to live preaching and singing of hymns.

Observation of the July 2016 Activity Calendar outside the main dining room on 7/15/16 at 2:00pm revealed the entire calendar was blank.

Review of the July 2016 Activity Calendar outside the main dining room on 7/18/16 at 2:00pm revealed:
-A calendar had been posted.
-For the week of 7/10/16 to 7/16/16 there were 22 hours of scheduled activities.
-On 7/13/16, Work in the Garden 10am to 12pm, Inspirational Speaker 1pm to 3pm.
-On 7/14/16, Preacher 9am to 10am, Game Day 1pm to 4pm
-On 7/15/16, Exercise 9am to 10am, Bingo 2pm to 4pm
-On 7/18/16, Morning Talk 9am to 10am,

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D 317	Continued From page 30 Monopoly 1pm to 3pm Observations in the living room, dining rooms, and throughout the facility on 7/15/16 at 8:20am to 10:15am revealed exercise activity was not offered as scheduled. Observations in the living room, dining rooms, and throughout the facility on 7/18/16 at 2:00pm revealed no residents were playing Monopoly. Interview with one Personal Care Aide (PCA) on 7/13/16 at 10:02am revealed: -She had worked at the facility for 5 months. -We do activities "sometimes." "I watched a movie...'Winn Dixie,' with them the other day and they loved it." Interview with a second PCA on 7/13/16 at 4:03pm revealed: -She had worked at the facility for 2 weeks. -She did not know who was responsible for activities or outings. Interview with a third PCA on 7/14/16 at 11:05am revealed: -She had worked at the facility for 2 years. -The staff all took turns doing activities with the residents. Interview with the Regional Manager on 7/18/16 at 10:10am revealed: -"We hung the Activity Calendar for July up today. We were just running behind." -One of the PCA's usually does the activities with the residents. -We have "sing alongs, churches come to play music, and have Sunday School." -"They play bingo." -"Last week they watched 'Winn Dixie.'"	D 317		

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D 317	Continued From page 31 -"This age group isn't going to color and do stuff like that." Telephone interview with the Administrator on 7/18/16 at 2:15pm revealed: -She was aware 14 hours planned activities should be offered weekly in the facility. -"They have a bowling game and puzzles." -"We don't have a lot of participation for all activities." -The residents like movie night.	D 317		
D 319	10A NCAC 13F .0905 (f) Activities Program 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that each resident shall have the opportunity to participate in at least one outing every other month. The findings are: Interview with the Regional Manager on 7/13/16 at 9:00am revealed the facility census was 31. Interview with eight residents during the initial tour on 7/13/16 from 9:00am until 11:30am revealed the following comments concerning outings:	D 319		

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-We have outings "sometimes. A little while back we went somewhere."
-"No we haven't been no where since the new people took over. They say we are but we never do. We have cookouts and stuff, but still we don't get to go nowhere."
-"I don't think that's on the schedule. They haven't said anything about trips. The staff has taken me to the store when I've asked."
-One resident attended church services regularly away from the facility.
-"None of the vans are running, cause there's no insurance on them. I wish they would do something about taking us out. If families don't come, we don't get to go nowhere."
-Three of the residents said they walk to the local store and the facility does not transport them for shopping.
-One resident stated he would like a field trip like to the zoo, but they never take him anywhere but to the medical appointments.

Review of the July 2016 Activity Calendar outside the main dining room on 7/15/16 at 2:00pm revealed:
-The calendar was blank.
-There were no outings listed.

Observation of the July 2016 Activity Calendar outside the main dining room on 7/18/16 at 2:00pm revealed:
-A calendar had been posted.
-There were no outings listed.

Interview with one Personal Care Aide (PCA) on 7/13/16 at 10:02am revealed:
-She had worked at the facility for 5 months.
-"Some" of the residents got to go on outings.
-She was unaware of any outings that had been made available to all residents who would want to

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D 319	Continued From page 33 participate. Interview with a second PCA on 7/13/16 at 4:03pm revealed: -She had worked at the facility for 2 weeks. -She did not know who was responsible for activities or outings. Interview with a third PCA on 7/14/16 at 11:05am revealed: -She had worked at the facility for 2 years. -The staff all took turns doing activities with the residents. Interview with the Regional Manager on 7/18/16 at 10:10am revealed: -"We try to do something once a month, but alot of them won't go." -"The last outing was to the fish camp to eat in May of this year." -Six residents participated in the outing to the fish camp. -"We don't drive our vans. We drive the Administrator's van. I'm not aware if our vans are insured or not. If I have to take somebody somewhere I just take my own personal car." -"We hung the Activity Calendar for July up today. We were just running behind." -"We went to the flea market in April. Only 2 residents went." Telephone interview with the Administrator on 7/18/16 at 2:15pm revealed: -"We offer to take the residents to [local discount store] or anywhere they want to go." -"We try to plan outings, but some of them don't save their money to go."	D 319		

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D 358	Continued From page 34	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to administer Norco, Roxanol, and Zithromax as ordered for 2 of 5 sampled residents (Resident #2 and #3). The findings are: A. Review of Resident #3's current FL2 dated 3/24/16 revealed: -A diagnosis of dementia. -The resident was documented as incontinent of bladder and bowel and requiring personal care assistance with bathing and dressing. 1. Review of a prescription for Resident #3 dated 6/1/16 revealed Norco 5/325mg (medication used to treat pain) 1 tablet every 6 hours as needed for back pain. Interview with Resident #3's family member on 7/14/16 at 2:15pm and 2:55pm revealed: -Resident #3 had recently been diagnosed with lung cancer and was under the care of Hospice. -He visited Resident #3 everyday. -Resident #3 was complaining of pain today. -He was going to ask staff and see if it was time	D 358		

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for another dose of pain medication for Resident #3.
-He wanted to speak to the Hospice Nurse concerning improved pain control for Resident #3 and possibly getting Resident #3 moved to the local Hospice House for care.

Interview with the Resident Care Coordinator (RCC) on 7/14/16 at 3:00pm revealed:
-She was responsible for administering medications for the entire facility on day shift.
-She had administered a Norco to Resident #3 on the noon medication pass and it was not time for another dose of the medication.
-The Hospice Nurse had seen Resident #3 right after lunch and had obtained an order for additional pain medication.

Review of Resident #3's July 2016 Medication Administration Record (MAR) from 7/1/16 to 7/15/16 at 10:15am revealed:
-Norco 5/325mg was documented as administered 9 occurrences from 7/1/16 to 7/15/16.
-There was one documented occurrence of Norco 5/325 being administered to Resident #3 on 7/14/16 at 2:22am.
-There were no other occurrences documented for 7/14/16.
-There were no documented occurrences for 7/15/16.

Interview with Resident #3's Hospice Nurse on 7/15/16 at 10:15am revealed:
-On 7/14/16 after 1pm, she had visited Resident #3 and he had told her his "stomach was hurting."
-She had asked the RCC when the resident had last received Norco for pain and the RCC had stated she had given him a dose at the noon medication pass.

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D 358	Continued From page 36 -On 7/15/16 when she arrived to visit Resident #3, she had asked the staff for a copy of Resident #3's MAR and according to the MAR, Resident #3 had received one Norco on 7/14/16 at 2:22am and no other doses for the rest of the day or for the morning of 7/15/16. -She had just asked the Medication Aide to give him dose of Norco, because the resident stated he was in pain. -On 7/14/16, she had gotten an order for Roxanol for Resident #3 from the physician. -She discovered when she arrived to the facility on 7/15/16 the Roxanol had not been delivered to the facility. Interview with the RCC on 7/18/16 at 10:53am revealed: -"I think I gave the Norco at 12pm" to Resident #3 on 7/14/16. -"I probably forgot to chart giving the Norco dose..." -"I just went and got the medicine" because the family member came in and was complaining Resident #3 was in pain and "insisted on a Norco." -Then the Hospice Nurse came in and gave us the order for the Roxanol. Observation of Resident #3's Norco on hand on 7/18/16 at 11:16am revealed: -There were 20 tablets of Norco 5/325mg tablets stored on the medication cart for the resident. -There two unused bubble packs containing of 30 tablets each of Norco 5/325mg stored in the RCC's desk drawer for Resident #3. Telephone interview with the facility pharmacy on 7/18/16 at 12:12pm revealed: -For the Norco 5/325mg order dated 5/19/16, 90 tablets had been dispensed to the facility for	D 358		

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Resident #3.
-For the Norco 5/325mg order dated 6/1/16, 60 tablets were in storage in the pharmacy for the resident, while 60 tablets had been dispensed to the facility for the resident.

Based on record review and observation of Resident #3 on 7/14/16, the resident was determined not to be interviewable.

2. Review of a physician's order for Resident #3 dated 7/14/16 revealed Roxanol 20mg/1ml give 0.25ml sublingual every 2 hours as needed for pain and shortness of breath.

Interview with Resident #3's family member on 7/14/16 at 2:15pm and 2:55pm revealed:
-Resident #3 had recently been diagnosed with lung cancer and was under the care of Hospice.
-He visited Resident #3 everyday.
-Resident #3 was complaining of pain today.
-He was going to ask staff and see if it was time for another dose of pain medication for Resident #3.
-He wanted to speak to the Hospice Nurse concerning improved pain control for Resident #3 and possibly getting Resident #3 moved to the local Hospice House for care.

Interview with the Resident Care Coordinator (RCC) on 7/14/16 at 3:00pm revealed:
-She was responsible for administering medications for the entire facility on day shift.
-Hospice had just written a new order for Roxanol (used to control pain) for Resident #3.
-The Roxanol order had been faxed over to the facility pharmacy and would be delivered by the pharmacy that evening.

Interview with Resident #3's family member on

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D 358	Continued From page 38 7/15/16 at 8:30am revealed: -He had gone that morning to the local Hospice House to talk to the staff there about moving Resident #3 to the Hospice House. -He had also spoke with them about increasing Resident #3's pain medication for better pain control. Review of Resident #3's July 2016 Medication Administration Record (MAR) from 7/1/16 to 7/15/16 at 10:15am revealed there was no documented entry for Roxanol. Interview with Resident #3's Hospice Nurse on 7/15/16 at 10:15am revealed: -On 7/14/16 after 1pm, she had visited Resident #3 and he had told her his "stomach was hurting." -On 7/14/16 after 1pm, she had gotten an order for Roxanol for Resident #3 from the physician. -She had offered to obtain the medication from a local pharmacy for the resident, however the RCC had told her it would be delivered from the facility pharmacy that evening. -She discovered when she arrived to the facility on 7/15/16 the Roxanol had not been delivered to the facility. -The facility "never notified us" the Roxanol had not arrived. -She was going to the local pharmacy to get the Roxanol for Resident #3. Interview with the RCC on 7/18/16 at 10:53am revealed: -The Hospice Nurse had obtained an order for Roxanol for Resident #3 on 7/14/16 around 1pm. -The order had to be signed by a physician before it could be sent to the facility pharmacy to be filled. -The order was not signed and faxed to the facility pharmacy until after 2:30pm on 7/14/16, so	D 358		

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D 358	Continued From page 39 the medication was not delivered in the evening tote. Observation of Resident #3's Roxanol on hand on 7/18/16 at 11:16am revealed was dispensed on 7/15/16 by a local pharmacy, not the facility pharmacy. Based on record review and observation of Resident #3 on 7/14/16, the resident was determined not to be interviewable. B. Review of the current FL2 for Resident #2 dated 6/9/16 revealed diagnoses included diabetes mellitus. Interview with the RCC on 7/14/16 at 11:45am revealed: -Resident #2 had been sweating and had low blood sugar on the morning of 7/13/16 and the Emergency Medical Services transported him to the Emergency Room (ER). -She picked Resident #2 up at the ER on 7/13/16 and the only papers they gave her was information about what to do for low blood sugar. -Any additional information of the 7/13/16 ER visit would be difficult to obtain because Resident # 2 would have to consent, but there was no other information. Review of the document dated 7/13/16 sent by the ER for Resident #2 revealed: -The preprinted forms contained generic information on how to treat low blood sugar. with Resident #2's name and identifying information on an applied label. -There was no documentation signed by the physician which listed diagnoses, treatment, laboratory values, vitals, time of treatment, orders, or referrals.	D 358		

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D 358	Continued From page 40 Review of Resident #2's ER visit (obtained by surveyor), dated 7/13/16, revealed: -The ER documented they treated Resident #2 for low blood sugar and noted, "vigorous cough." -Diagnoses included "hypoglycemia" and "bronchitis." -Treatment included an order for "Z-pack" and to follow up with the primary care physician for a pulmonary consult. (Z-pack is an antibiotic.) Interview with the Regional Manager on 7/15/16 at 10:07am revealed: -They did not have any orders for Resident #2 from the ER. -They had not contacted the ER for any more documentation from the 7/13/16 visit for Resident #2. Observation of Resident #2 on 7/15/16 at 9:45am revealed he was walking down the hall and coughing. Interview with the RCC on 7/18/16 at 10:00am revealed: -They had obtained the Z-pack antibiotic for Resident #2. -The ER called the prescription in to the pharmacy and the Z-pak was on hand. -She was not aware of any referrals made by the ER physician and had no other documentation from the 7/13/16 ER visit. Observation of the medications on hand for Resident #2 on 7/18/16 at 10:00am revealed 6 tablets Zithromax 250mg dispensed on 7/15/16, take 2 tablets the first day and 1 tablet the next four days, and 3 tablets remained in the cassette. Observation of Resident #2's 7/1/16 through	D 358		

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D 358	Continued From page 41 7/18/16 Medication Administration Record (MAR) revealed no documentation of the administration of the Zithromax 250 mg through the 8:00am administration on 7/18/16. Interview with the Regional Manager on 7/18/16 at 10:15am revealed she could open the electronic MAR and show surveyor where they had added a medication which was on another page other than the MAR they had printed. Review of the electronic MAR screen on 7/18/16 at 10:15am revealed the Zithromycin 250 mg was documented as administered to Resident #2 on 7/16/16 and 7/17/16 at 11:00am, three days after the ER visit. Interview with the Regional Manager on 7/18/16 at 1:38pm revealed she had obtained a copy of Resident #2's ER visit and would take care of the pulmonary referral as recommended.	D 358		
D 393	10A NCAC 13F .1008 (b) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observations, interviews, and record rerviews, the facility failed to properly store excess supply of Schedule II medications under double lock and proper supervision upon receipt	D 393		

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D 393	Continued From page 42 of controlled medications. The findings are: Observation on 7/13/16 at 12:11pm of the facility's medication administration carts revealed: -The facility had 2 medication carts for the residents' medications. -The medication carts were lockable. -The medication carts contained a separate locked drawer inside the individual carts for storage of controlled drugs. Observations at various times on 7/13/16, 7/14/16, 7/15/16, and 7/18/16 of the Resident Care Coordinator (RCC) office revealed: -There were two doors used to access the office. -One door opened to the outside facility grounds and was kept unlock and ajar. The door was unlocked. -The second door opened to the main resident living room and was kept unlock and ajar. The door was unlocked. -The RCC or Regional Manager were intermittently in the office. Review of Resident #3's current FL2 dated 3/24/16 revealed diagnoses of dementia. Review of a prescription for Resident #3 dated 6/1/16 revealed Norco 5/325mg (medication used to treat pain) 1 tablet every 6 hours as needed for back pain. Observation in the RCC's office right desk drawer on 7/18/16 at 11:16am revealed: -There two unused bubble packs containing of 30 tablets each of Norco 5/325mg stored in the drawer for Resident #3. -The desk drawer was not lockable.	D 393		

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D 393	Continued From page 43 Telephone interview with the facility pharmacy on 7/18/16 at 12:12pm revealed: -Some of the facility's controlled medications for residents were stored at the pharmacy, because the facility did not have the storage capacity to store all the residents controlled medications at one time. -For example, the pharmacy was holding 60 tablets of Norco 5/325mg tablets in the pharmacy storage for Resident #3, because the facility did not have room to store it on their medication carts. Interview with the RCC on 7/18/16 at 1:45pm revealed: -She had stored the Norco 5/325mg tablets in the desk drawer for Resident #3, because there were too many to fit on the cart. -The desk drawer was not lockable. -"Most of the time" the door to the RCC's office was kept closed and locked. -She was the only employee who had a key to unlock the RCC office. Telephone interview with the Administrator on 7/18/16 at 2:15pm revealed: -Facility policy was to store all controlled medications under double lock in the medication carts. -The facility had an arrangement with their pharmacy to store controlled medications for the facility when there was not enough storage space in the medication cart locked drawer. -She was unaware controlled medications had been stored in the RCC's office desk drawer.	D 393		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 44 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a resident received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules an regulations in the area of housekeeping and furnishings and medication aide training. The findings are: A. Based on observations, interviews, and record reviews, the facility failed to assure the home was maintained clean and free of all obstructions and hazards as related to resident rooms with bed bugs, two unsecured toilet seats, a mattress hanging over boxsprings, box springs hanging below the bed rail, unsecured window blinds, closet doors off track and inoperable, exposed light sockets, an extension cord, and facility areas that were not clean. [Refer to Tag D 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Unabated B Violation).] B. Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled Medication Aides (Staff A and B) who were hired after 10/1/13 as Medication Aides (MA), had successfully completed the 15 hour medication administration training. [Refer to Tag D 935 G.S. § 131D-4.5B (b) Adult Care Home	D912		

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D912	Continued From page 45 Medication Aides; Training and Competency Evaluation Requirements (Type B Violation).]	D912		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if	D935		

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D935	Continued From page 46 applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 2 of 3 sampled Medication Aides (Staff A and B) who were hired after 10/1/13 as Medication Aides (MA), had successfully completed the 15 hour medication administration training. The findings are: A. Review of Staff A's personnel record revealed: -Staff A was hired on 6/16/15 as a Medication Aide (MA). -Staff A had successfully passed the written Medication Aide Test on 1/4/11. -Staff A had completed the Medication Clinical Skills evaluation on 5/2/16. -There was no documentation Staff A completed the 5, 10, 15 hour medication training program. Observation of Staff A, MA, on 7/14/16 at 3:05pm revealed Staff A was preparing and administering 2pm scheduled medications to residents. Interview with Staff A, MA, on 7/18/16 at 1:45pm revealed she could not remember if she had	D935		

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D935	Continued From page 47 taken the 5, 10, 15 hour medication training program classes. Interview with the Regional Manager on 7/18/16 at 10:40am revealed: -Staff A had received the 15 hour medication administration training. -She could not find the certificate of the training in Staff A's personnel record. -She would contact the facility Nurse Consultant who did the training and get another copy of the certificate. B. Review of Staff B's personnel record revealed: -Staff B was hired on 5/2/16 as a MA. -Staff B had successfully passed the written Medication Aide Test on 7/6/16. -Staff B had completed the Medication Clinical Skills evalaution on 5/2/16. -There was no documentation Staff B completed the 5, 10, 15 hour medication training program. Interview with the Regional Manager on 7/18/16 at 10:40am revealed: -Staff B, currently worked as a MA in the facility usually on the 7pm to 7am shift. -Staff B had begun administering medications to residents as soon as he had taken the Medication Aide test and had completed her Medication Clinical skills checkoff. -Staff B had received the 15 hour medication administration training. -She could not find the certificate of the training in Staff B's personnel record. -She would contact the facility Nurse Consultant who did the training and get another copy of the certificate. _____ A Plan of Protection was provided by the facility	D935		

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D935	Continued From page 48 on 7/18/16 as follows: -5, 10 or 15 hour medication training per regulation will be completed with all new Medication Aides. -Current Medication Aides who have not had the training will be removed from the medication administration cart until 5 hour training is completed. -15 hour medication training will be completed for medication aides within 60 days of date of hire. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 1, 2016.	D935		