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	HAL034084	A. BUILDING: _____ B. WING _____	R-C 07/06/2017

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FORSYTH VILLAGE	5100 LANSING DRIVE WINSTON SALEM, NC 27105

(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 Forsyth County Department of Social Services conducted a follow-up survey and complaint investigation on 07/05/17 - 07/06/17.	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 and interviews, the facility failed to assure the walls, floors and ceilings in 9 residents' rooms and bathrooms (rooms 1, 4, 9, 10, 15, 16, 17, 18, 35), 6 common bathrooms and 3 of 3 hallways were kept clean and in good repair. The findings are: Observations during the facility tour on 7/05/17 and 7/06/17 revealed: -The facility was an older building and was divided into 3 hallways: On the A hall were rooms 1-13, on the B hall were rooms 14-22, and on the C hall were rooms 22-38. -There were 2 housekeepers seen at the common bathrooms and going into and out of residents' rooms. Observations made on the A hallway during the	D 074		

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D 074	Continued From page 1 facility tour on 7/05/17 and 7/06/17 revealed: -There was yellow or brown stained, cracked, or missing caulk behind and around the toilets, sinks and floor found in most bathrooms, including rooms 9 (yellow-brown stains around the toilet), the common bathroom hall (missing caulk at base of toilet), and the lobby men's bathroom (missing caulk around the sink). -The telephone room had an approximately 3 inch round hole in the wall behind the door. -The common bathroom had approximately 6 inches of damaged baseboard directly below the soap dispenser. -The lobby women's bathroom had brown stains on the baseboard, and approximately 2 feet of the baseboard was missing behind the toilet. -There were 2 missing floor tiles at the front exit door near the beauty shop with a piece of 3 foot x 5 foot torn carpet lying over it that was a potential tripping hazard. -The tub room had an approximately 6 inch square plate on the wall behind the door, which covered a hole of unknown size, but still exposed approximately 1/2 inch of the hole at the top left corner of the repair. It was missing caulk. -The lobby men's bathroom had a ½ inch round hole on the wall to the left of the light switch. -Room 1 had an approximately 3 inch round and 1/4 inch deep area of chipped paint on the left wall next to foot of the metal bed frame. -Room 4 had a 2 1/2 inch x 3 inch hole at the base of the bedroom door. -Room 10 had a wall patched in 2 areas behind a bed with a thick layer of caulking that was not smooth or painted. Interview on 7/06/17 at 8:45 am with the resident residing in room 4 revealed he was "told the hole in his door would be fixed 3 to 4 months ago (by maintenance), but it had not been done yet".	D 074		

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D 074	Continued From page 2 Observations made on the B hallway during the facility tour on 7/05/17 and 7/06/17 revealed: -There was yellow or brown stained, cracked, or missing caulk behind and around the toilets, sinks and floor found in most bathrooms including room 15 (gaps between wall boards in the shower missing caulk and missing caulk around the toilet), 17 (caulk cracked from tub to wall, and the sink needed to be caulked to the wall), and 18 (yellow-brown stained, old caulk around the toilet), and the common bathroom next to room 15 (missing caulking around the base of the toilet). -The shower room had a damaged and rusting door frame. -Room 16 had a ceiling vent with peeling paint. -Room 17 had molding loose from the door jam and a hole around the plumbing pipe into the wall. Observations made on the C hallway during the facility tour on 7/05/17 and 7/06/17 revealed room 35 had a baseboard loose from the wall behind the toilet. Interview on 7/06/17 at 9:45 am with the resident residing in room 35 revealed he was aware of the loose baseboard behind the toilet, and stated "the toilet still leaks, they are not finished repairing it." Review of the local Environmental Health inspection report dated 5/23/17 revealed: -The sanitation score was 85.5. -"Toilet caulk throughout facility needs to be smoothed and added where missing or soiled. Floors shall be easily cleanable." -"Floor cleaning needed throughout resident rooms...in community spaces...in areas where baseboards are soiled. Floors shall be easily cleanable." Two demerits were taken off	D 074		

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regarding floors, walls and ceilings.
-Walls and ceilings general comments included: "B hall shower room wall missing trim/ metal wall rusting at bottom; room 17 (molding loose from door jam, hand sink needs caulked to wall, hole around plumbing pipe into wall);... B hall restroom (wall cleaning needed); snack room (paint chipping from vent); room 1 (chipped wall paint); closet doors soiled in a few rooms. Walls and ceilings shall be cleanable and maintained clean."
-"Rooms inspected: 34, 35, 21, 22, 32, 17, 1, 2."
-"Dusty vent present in men's restroom in lobby."
-The same conditions as described above were observed during the facility tour on 7/05/17 and 7/06/17.

Interviews from 4 residents during the initial facility tour on 7/05/17 from 9:00 am to 11:00 am revealed:
-The facility hired 2 housekeepers.
-Maintenance staff say "they are fixing things and have been painting some areas".
-Maintenance "have not been fixing things" that needed repair.

Interviews on 7/05/17 at 9:20 am with 2 Housekeepers revealed:
-Both had worked at the facility for 5 months.
-They cleaned baseboards and beds, swept and mopped floors as part of their daily duties.
-The facility had a maintenance man who was responsible for the repairs that needed to be done.
-Repair needs were reported to the (named) Maintenance staff.

Interviews with 6 staff members on 7/05/17 and 7/06/17 at various times revealed:
-Maintenance had been painting and caulking in the facility.

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-Maintenance needs were reported to a maintenance staff member, but "he also performs transportation needs for the residents", so cannot complete everything that needed to be repaired.
-Maintenance staff were in the building every day, Monday through Friday., and the Regional Maintenance Director (RMD) was "at the facility about 3 times per week".
-A note was left for the maintenance staff if repairs were needed, or the staff reported the need in person if the maintenance staff were on site at the time.

Interviews 7/06/17 at 11:45 am with the Administrator-in-Charge revealed:
-Housekeeping and maintenance were fixing the repairs from the Sanitation report citations, including caulk and wall repairs.
-They had two housekeepers who were responsible for cleaning the facility.
-The facility had a maintenance staff who was responsible for the repairs that needed to be done.

Telephone interview on 7/06/17 at 1:05 pm with the RMD revealed:
-He had worked at the facility as the RMD since September 2016.
-They were fixing the repairs from the Sanitation report citations dated 5/23/17.
-He was aware of the missing caulk in many bathrooms as it had been removed to reapply correctly.
-Some of the patched walls were waiting for painting.
-He was discovering the facility needed numerous repairs, but it was an old building.
-Any repair needs were reported to "the Administrator who then gave him the money" for any approved repairs,

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D 074	Continued From page 5 -The Administrator had to give him money for any needed repairs, but most of his budget lately had gone to another facility.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; 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 the furniture in 13 out of 38 residents' rooms (rooms 2, 3, 5, 6, 7, 10, 14, 17, 18, 19, 25, 35, 38) was kept clean and in good repair as evidenced by nightstands and chests of drawers with missing or broken handles. The findings are: Observations during the facility tour on 7/05/17 and 7/06/17 revealed: -Rooms 2, 5, 6, 7 and 25 each had a chest of drawers with missing and broken handles. -Room 3 had a nightstand and 2 of 2 chest of drawers with missing handles. The nightstand had 1 of 2 drawer knobs missing. One chest of drawers had 1 of 6 handles missing. A second chest of drawers had 5 of 6 handles missing. -Room 10 had a nightstand and chest of drawers with missing and broken handles. -Room 14 had 2 of 2 chest of drawers with missing handles. One chest of drawers had 1 of 6 handles missing. A second chest of drawers had 3 of 8 handles missing.	D 076		

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D 076	Continued From page 6 -Room 17 had 2 of 2 chest of drawers with missing handles. One chest of drawers had 3 of 10 handles missing. A second chest of drawers had 1 of 10 handles missing. -Room 18 had 1 of 2 nightstands and 1 of 2 chest of drawers with missing handles. The nightstand had 1 of 2 drawer knobs missing. The chest of drawers had 3 of 6 handles missing. -Room 19 had a nightstand and 2 of 2 chest of drawers with missing handles. The nightstand had 2 of 2 drawer knobs missing. One chest of drawers had 1 of 6 handles missing. A second chest of drawers had 5 of 5 handles missing. -Room 35 had a chest of drawers with 1 of 6 handles missing. -Room 38 had a nightstand with 1 of 2 broken handles and a chest of drawers with 1 of 6 broken handles. Review of the local Environmental Health inspection report dated 5/23/17 revealed: -The sanitation score was 85.5. -Two deductions were given for "Furniture clean and in good repair." -"Furniture chipping/damaged throughout facility with ...missing drawer/handle pulls." -"Furniture ...shall be maintained clean and in good repair." Interviews from multiple residents during the facility tour on 7/05/17 and 7/06/17 revealed: -"My chest of drawers is hard to open without handles." -"My chest of drawers has been broken for a long time. It would be nice to have handles." -"When anything is broken, we tell maintenance about it." -"Maintenance is aware my chest of drawers is broken. I can still open it."	D 076		

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D 076	Continued From page 7 Interview on 7/06/17 at 11:45 am with the Administrator in Charge (AIC) revealed: -She was not aware that 13 out of 38 resident rooms had chest of drawers or nightstands with missing and broken handles. -The Regional Maintenance Director (RMD) was responsible for replacing the handles. Interview on 7/06/17 at 1:05pm with RMD revealed: -It was his responsibility to replace the missing or broken handles on the furniture. -Replacing the handles on the chest of drawers and nightstands was on his list of things to fix. -He had the items he needed to do it, but he had not gotten to it yet.	D 076		
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: Type B Violation Based on observations, interviews, and record reviews the facility failed to maintain the facility in a clean and orderly manner free of obstructions and hazards in regards to bed bugs, 10 of 41	D 079		

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rooms (rooms #5, #11, #14, #15, #22, #23, #28, #38, a common area next to room #3, and the snack room).

The findings are:

Review of pest control company service inspection report dated 6/26/17 at 1:06 pm revealed:
-A K9 with handler searched the building for the odor of live bed bugs and viable eggs.
-The following locations were confirmed for bed bugs: common area next to room #3, craft room, #5, #11, #14, #15, #22, #28, #38.
-Room #23 was not searched due to fresh paint.

Interview on 7/05/17 with the Medication Aide (MA) at 9:15 am revealed:
-The activity room the surveyors were in had bed bugs and we were moved.
-The residents in rooms with bed bugs were not moved because of so many rooms infested and nowhere to move them.
-She was aware of 11 rooms with bedbugs.
-She stated nothing was done and the administration was waiting on the owner to take care of it.
-Some of the residents were complaining of bites from the bugs.
-A resident from room #6 complained about bed bug bites and after found bed bugs in room #6 on the bed, removed the linens and clothes and put them in plastic bags and notified the Assistant Administrator.
-She told housekeeping to spray the room.

Interview on 7/05/17 with a housekeeper at 9:20 am revealed:
-He was hired 5 months ago.
-There had not been any new housekeepers

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hired since he had been at the facility.
-He was responsible for sweeping, and mopping the floors, stocking toilet paper, paper towels and soap in all of the rooms and bathrooms and emptying the trash from all of the rooms.
-He was to spray any area where bed bugs were reported or seen with a common bed bug and flea spray and had not sprayed any beds at that point this morning.
-He was to report any sightings of bed bugs to the office staff.
-He did not strip or make the beds.
-The MA were responsible for stripping and changing the bed linens.

Interview on 7/05/17 with a second housekeeper at 9:20 am revealed:
-He was hired 5 months ago.
-There had not been any new housekeepers hired since he had been at the facility.
-He was responsible for sweeping, and mopping the floors, stocking toilet paper, paper towels and soap in all of the rooms and bathrooms and emptying the trash from all of the rooms.
-He was to spray any area where bed bugs were reported or seen with a common bed bug and flea spray.
-He was to report any sightings of bed bugs to the office staff.
-He reported several rooms with sighting to the medication aide (MA) this week but cannot recall the room numbers, there was "too many".
-He did not strip or make the beds.
-The MA were responsible for stripping and changing the bed linens.

Observation on 7/05/17 of a resident residing in room #6 at 9:35 am revealed:
-The mattress was stripped and clothes were piled up on dresser.

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D 079	Continued From page 10 -3 live bed bugs found under mattress. -5 red bite marks noted on his arms. Interview on 7/05/17 with a resident residing in room #6 at 9:35 am revealed: -He complained of bed bugs to the 1st shift MA. -The MA stripped my bed and took the sheet to the laundry just 5 minutes ago. -Housekeeping was to spray his room but had not done so yet. -He complained of bed bug bites to his upper body. Interview on 7/05/17 with the resident residing in room #28 at 10:16 am revealed: -He had bed bugs in his room last month and stated that he had bites then. -The housekeeper sprayed his room last month, not sure of the date. -He was itching a lot on his back, chest and abdomen and reported it to the MA on duty 07/06/17. Observation on 7/05/17 of the resident residing in room #28 at 10:16 revealed: -The MA came in to check the skin of the resident residind in room #28. -The chest, abdomen and back of the resident residing in room #28 was clear of bug bites but had red marks from the excessive scratching. Interview on 7/05/17 with the pest control exterminator at 5:00 pm revealed: -He stated that 3 more rooms were infested with bed bugs, rooms #5, #6 and #15. -He could not treat the rooms until prepayment was made. -"The facility had a contract with the pest control company". -"There had been issues with payment before".	D 079		

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-Once he received payment then he would treat the 3 rooms with active bed bugs and then schedule to come out and inspect again and retreat after that payment was made.

Interview on 7/05/17 with the Regional Maintenance Director at 5:30 pm revealed:
-The facility was treating for bed bugs.
-He had the housekeepers spray for bed bugs daily with a common bed bug and flea spray.
-A log book was kept to show the rooms sprayed daily.
-He was not able to find the log book.
-He was aware room #15 was infested with bed bugs.
-He stated the pest control would be out to treat room #15 after payment made.

Interview on 7/06/17 with the Administrator-in-Charge at 8:30 am revealed:
-The pest control came out yesterday to treat 3 rooms that were infested with bed bugs: rooms #5, 6 and #15.
-"It was the responsibility of the owner of the building to pay to have the rooms treated".
-She was told that she would have to pay up front to have room #15 treated and 2 other rooms.
-After she prepaid to have the 3 rooms treated and if another treatment was required, they would have to pre-pay for the service.
-The health department and the pest control told her about room #5, #6 and #15 having bed bugs and room #15 was the worst and had residents in it.
-The procedure when bed bugs were found was to bag the resident's clothes and linens for washing at a local laundromat for the hotter washer/dryers, and remove the residents from the room.
-No resident could be moved because "there was

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no place to move them to".
-The common areas need to be sprayed by the pest control company and they will have that done as soon as possible.
-If live bugs were seen, then a heat treatment was ordered. The residents could return in 24 hours, but we wait until after the follow-up exterminator inspection.
-She was unable to verbalize the procedure if there was no rooms left to move residents to and wait on the follow up inspection from the pest control.
-Our housekeepers were responsible for spraying any rooms that have bugs.

Interview on 7/06/17 with the Business Office Manager at 9:00 am revealed room #23 was vacant and was treated for bed bugs 2 months ago.

Observation on 7/06/17 of activity/craft room at 9:00 am revealed the Activity Director and one resident were playing a game in the activity room and room had not been treated for bed bugs.

Observation on 7/06/17 of room #15 at 9:10 am revealed:
-Both beds were stripped.
-There were dead bed bugs found under one mattress in the room.
-Clothes were piled up on the floor.
-A resident was laying on the bed without sheets.

Interview on 7/06/17 with a resident from room #15 at 9:10 am revealed:
-She was just moved from room #8 two weeks ago because of bed bugs.
-She saw bed bugs in this room but no complaints of bites.

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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 079	Continued From page 13 Observation on 7/06/17 of room #5 at 9:15 am revealed: -The bed was stripped down. -A resident from room #14 was sitting on the bed in room #5. -Clothes were piled up on the end of the bed the resident from room #14 was sitting on. -The resident residing in room #5 was sitting in a chair and complained of bites to his lower body. Interview on 7/06/17 with a resident residing in room #5 at 9:15 am revealed: -He was moved to another room for a week and then back to Room #5 due to bed bugs. -He has been itching but no bites were visible. -"This room has not been sprayed". -He told the housekeeper this morning about the itching. -His bed was stripped because it was time to wash the sheets. Observation on 7/06/17 at 9:20 am revealed a resident from room #15 sitting on a bed in room #38. Observation on 7/06/17 of activity/craft room at 2:00 pm revealed arts and crafts projects with the Activity Director and 8 residents in the activity room with 8 residents. _____ The facility failed to maintain the facility in a clean and orderly manner free of obstructions and hazards in regards to bed bugs (rooms #5, #11, #14, #15, #22, #23, #28, #38, a common area next to room #3, and the snack room). These failures were detrimental to the health and safety of the affected resident, causing bed bug bites and itching, sleep pattern interruption, having to stay out of room and constitutes a Type B Violation.	D 079		

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D 079	Continued From page 14 A Plan of Protection was provided by the facility on 7/06/17. -The facility will immediately remove residents from rooms and contact the pest control company. -The facility will schedule the pest control company to come out 7/07/17 to treat room and inspect the whole facility. -The housekeepers and staff will check rooms daily for bed bugs. -The Administrator in Charge will check weekly for 30 days and review monthly. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED August 20, 2017.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to provide adequate supervision at meals to prevent residents (Resident #4) from eating after another resident (Resident #5) who had a communicable disease. The findings are:	D 270		

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D 270	Continued From page 15 Observation of the lunch meal service on 7/05/17 from 12:30 pm to 1:05 pm revealed: -There were 10 tables in the dining room, with 2 to 5 residents per table. -A cook plated the food in the kitchen area from a heated food cart for the Personal Care Aides (PCAs) to serve to residents. -There were 3 staff serving the meal plates and removing the plates when the residents were finished. -Resident #4 arrived at 12:30 pm and was served her lunch plate at 12:38 pm. Her meal consisted of water, tea, french fries, diced carrots and a sloppy joe on bun. She consumed 100% of her sloppy joe and tea, and but did not consume any french fries, carrots or water. Her plate was removed by staff at 12:55 pm, but she kept her empty tea glass with ice. She remained at the table even after her 2 other table mates had left. -The serving staff were informed at 12:40 pm by another staff that Resident #5 did not want lunch. No plate was placed at her table space, which was at the table with Resident #4. -Resident #5 arrived at 1:00 pm and was immediately served her lunch meal of sloppy joe on bun, french fries, diced carrots, and water. She took 2 bites of the sloppy joe then pushed her plate away towards the middle of the table, stood up and left at 1:03 pm. -At 1:03 pm, Resident #4 reached for Resident #5's plate and pulled it in front of her, then took 2 bite of the sloppy joe, in the vicinity of the bite areas from Resident #5. She then placed the sloppy joe back on the plate and pushed the plate away. -At 1:05 pm, the serving staff removed Resident #5's plate from the table, saying, "let me take this", and Resident #4 left the dining room. -At the time of the incident there were 6 residents	D 270		

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and 3 staff in the dining room. The staff were nearly finished cleaning the tables as they had removed plates as the residents finished their meal and left the dining room.

Interviews and record reviews of Resident #4 and Resident #5's records revealed the following:

Review of Resident #5's current FL2 dated 9/09/16 revealed a diagnosis of hepatitis C.

Review of Resident #5's record revealed:
-A physician's routine visit dated 5/28/17 with documentation of a plan for gastrointestinal (GI) physician referral for "Hep C Viral Load elevated" (how much of the hepatitis C virus was in the blood, and was used to confirm a diagnosis and monitor the progress of treatment).
-No Hep C Viral Load laboratory level result was documented.

Interviews on 7/05/17 at 3:51 pm and 7/06/17 at 9:37 am with Resident #5 revealed:
-Resident #5's teeth hurt, so it was "painful to eat, and not what I wanted. I will taste the food, and if not good, I leave it. The girl across the table eats my food some of the time."
-She had not seen a dentist in years, but reported her "teeth have been rotten for at least a year. Some teeth have broken off and have bled in the past 3 months."

Observation on 7/05/17 at 3:51 pm of Resident #5's mouth revealed:
-The top right tooth was broken off, several teeth had been pulled, and many were black.
-There was no bleeding in the mouth.
-Resident #5's right side of her face and eye was slightly swollen.

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D 270	Continued From page 17 Interview on 7/06/17 at 10:00 am with a Medication Aide (MA) revealed: -She had observed broken teeth on the right, top, and the resident had reported the teeth were bleeding in her mouth. -Resident #5 has not seen a dentist since she was admitted here on 09/01/16. Review of Resident #4's current FL2 dated 1/09/17 revealed there was documentation of intermittent confusion. Interview on 7/06/17 at 8:30 am with Resident #4 revealed: -She often shared food with people at her table. -She received "plenty to eat, but does not like that so much food is wasted". -She was told not to eat other resident's food. Interview on 7/05/17 at 1:05 pm with a PCA/MA revealed: -She was a PCA and MA at the facility for more than 2 years. -She also assisted in the dining room at meal times in addition to her PCA duties. -She had removed Resident #5's lunch plate since the resident had left the dining room. -She was not aware Resident #4 had taken a bite off Resident #5's sloppy joe. -If she "saw a resident give another food (from their plate), she would stop it and take the food away. That usually does not happen." Interview on 7/06/17 at 9:00 am with a second MA revealed: -She had never seen Resident #5 give her food to Resident #4. -The residents were aware they were not to share food. -Due to Resident #5's diagnosis, there was a	D 270		

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bigger risk in food sharing.

Telephone interview on 7/06/17 at 10:50 am with a local Health Department Nurse revealed hepatitis C was transported via blood and body fluids, including saliva.

Interview on 7/06/17 at 11:45 am with the Resident Care Coordinator revealed:
-She "expected staff to serve, assist the residents as necessary and to watch over the dining room to ensure right diets were served to the residents".
-"Staff and residents have been told many times not to eat from, or ask for another resident's plate."
-She unaware Resident #5 gave food to her tablemates or to Resident #4, and was aware of Resident #5's diagnosis.
-The "residents have been told at council meetings not to share or take food, cigarettes or beverages from other residents, and to not eat, drink or smoke after the one another."
-She would contact the Nurse Practitioner (NP) or physician to update them on the situation and "see if we can get lab work drawn".

Interview on 7/06/17 at 11:45 am with the Administrator-in-Charge (AIC) revealed:
-She had been the AIC for 5 years.
-"Staff and residents have been told many times not to eat from, or ask for, another resident's plate."
-She was not aware that Resident #5 gave food to her tablemates or to Resident #4.
-She was aware of Resident #5's diagnosis.

Telephone interview on 7/06/17 at 11:54 am with the NP revealed:
-He was the NP for both Resident #4 and

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D 270	Continued From page 19 Resident #5. -"It was a minute possibility of (another resident) contracting hepatitis C" from eating after Resident #5. -Resident #5's "viral load was elevated and he was only monitoring her labs until the GI physician takes her as a patient". -"It was a concern if another resident eats or drinks after" Resident #5, and "if bleeding in the mouth, that would be the biggest concern" of transmission to another person. -"The potential risk of transmission is higher because the possibility of the bleeding (in the mouth) and since Resident #5 had reported bleeding teeth recently." -The supervision of the residents should be adequate enough to make sure the residents ate their own food. -There was increased potential of transmission with residents eating other resident's food. _____ The failure of the facility to supervise residents in the dining room resulted in one resident (Resident #4) eating food after another resident (Resident #5) with a known diagnosis of hepatitis C, which is a disease transmitted by blood and body fluids, putting the resident at risk for contracting hepatitis C. This was detrimental to the safety and welfare of Resident #4 and constitutes a Type B violation. _____ The facility provided the following Plan of Protection on 7/06/17 as follows: -The Administrator-in-Charge (AIC) will have a meeting with all staff and residents immediately and on every shift. -Immediately staff will remove all plates from tables when residents are finished. -The physician will be called if a resident eats off other residents' plates and the physician's orders	D 270		

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D 270	Continued From page 20 will be followed. -The AIC will check compliance weekly for 30 days and then monthly thereafter. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 20, 2017.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure health care needs were met for 1 of 5 sampled residents (#5) as related to failure to contact the dentist for a resident (#5) who was experiencing tooth pain, bleeding gums and difficulty eating because of broken teeth over the past three months and had not seen a dentist in almost 2 years. The findings are: Review of Resident #5's current FL2 dated 9/09/16 revealed: -Diagnosis of hepatitis C. Review of Resident #5's record revealed: -A physician's routine visit dated 5/28/17 with documentation of a plan for gastrointestinal (GI)	D 273		

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physician referral for "Hep C Viral Load elevated" (how much of the hepatitis C virus was in the blood, and was used to confirm a diagnosis and monitor the progress of treatment).
-No Hep C Viral Load laboratory level result was documented.

Interviews on 7/05/17 at 3:51 pm and 7/06/17 at 9:37 am with Resident #5 revealed:
-Resident #5's teeth hurt, so it was "painful to eat, and not what I wanted. I will taste the food, and if not good, I leave it. The girl across the table eats my food some of the time."
-She had tooth pain at her top right tooth, where it was broken and the right side of her face was slightly puffy and tender.
-She had reported the tooth pain to staff and wanted a dental appointment.
-She had not seen a dentist in years, but reported her "teeth have been rotten for at least a year. Some teeth have broken off and have bled in the past 3 months."

Observation on 7/05/17 at 3:51 pm of Resident #5's mouth revealed:
-The top right tooth was broken off, several teeth had been pulled, and many were black.
-There was no bleeding in the mouth.
-Resident #5's right side of her face and eye was slightly swollen.

Interview on 7/06/17 with the Administrator-in-Charge at 8:30 am revealed:
-She was not aware Resident #5 needed to see the dentist.
-The MAs were responsible for calling the doctor and setting the appointments.
-The MAs were to let the office manager know of all appointments and the office manager would record them in the calendar and make travel

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D 273	Continued From page 22 arrangements. -She stated the calendar did not have an appointment for Resident #5 to see the doctor or dentist for the broken teeth, bleeding gums or swelling in the face. Interview on 7/06/17 at 10:00 am with a Medication Aide (MA) revealed: -She was not aware Resident #5 was having problems with pain, broken teeth and bleeding gums. -She had observed on 7/06/17 at 10:00 am broken teeth on the right, top, and the resident had reported the teeth were bleeding in her mouth. -Resident #5 has not seen a dentist since she was admitted here on 09/01/16. Telephone interview on 7/06/16 with Resident #5's Nurse Practitioner at 11:54 am revealed she was not aware of Resident #5 was having tooth pain, swelling or bleeding. _____ The facility's failure to contact the dentist for Resident (#5) who was experiencing tooth pain, bleeding gums and difficulty eating because of broken teeth over the past three months and had not seen a dentist in almost 2 years. This failure was detrimental to the health and safety of the affected resident, and neglectful causing pain, inability to eat, and the quality of life of this resident was greatly affected and constitutes a Type B Violation. _____ A Plan of Protection was received from the facility on 7/27/17. -Once a month the Resident Care Coordinator (RCC) will check all resident's mouth for broken teeth, sores or bleeding gums, then the RCC will notify the doctor/dentist.	D 273		

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D 273	Continued From page 23 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 20, 2017.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the dining area was clean and protected from contamination as evidenced by flies being in the dining room. The findings are: Observations on 7/5/17 from 12:35pm to 12:50pm of lunch being served in the residents' dining room revealed: -Multiple flies in the dining room. -Flies landing on each of the ten dining tables, on the residents and on the residents' food. -Once residents had vacated a table with four chairs, nine flies landed on the table. -An exit door without a screen to the smoking area located directly across from the dining room entrance. Interviews on 7/5/17 at 12:40pm with a Medication Aide (MA) and a Personal Care Aide (PCA) present in the dining room revealed: -Flies in the dining room were bad during the	D 282		

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summer time.
-Flies would come in from the nearby door when residents would go outside to the smoking area.
-They were not aware of anything that had been done to control the flies.

Interviews on 7/5/17 at 12:45pm with multiple residents in the dining room revealed:
-Flies were usually not that bad in the dining room.
-Flies had been awful in the dining room lately.
-Flies had been bad in the dining room for the past 2-3 weeks.
-Flies were bad in the dining room and the staff weren't doing anything about them.

Observations on 7/5/17 from 5:40pm to 6:00pm of dinner being served in the resident's dining room revealed:
-Flies were in the dining room.
-Fewer flies were in the dining room than what had been observed during the lunch meal.

Interview on 7/6/17 at 9:00am with a MA revealed:
-Staff had been informed during a staff meeting on 7/5/17 that administration had purchased a spray to try and control the flies.
-She was unsure if the spray had been used yet.
-Flies were worse this summer than last summer.
-Last summer the staff hung bags of bleach and water outside of the exit doors not utilized by residents to help ward off the flies.
-The solution of bleach and water had helped to reduce the number of flies seen last summer.

Interview on 7/6/17 at 11:45am with the Administrator in Charge (AIC) revealed:
-She had purchased fly spray after the lunch meal on 7/5/17.

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D 282	Continued From page 25 -The staff had used the fly spray between the lunch and dinner meals on 7/5/17. -She felt that it had helped to decrease the number of flies in the dining room. -She planned to continue to have the staff utilize the fly spray when the dining room was unoccupied.	D 282		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure residents received care and services that are adequate, appropriate and in compliance with federal and state laws and rules and regulations related to housekeeping and furnishings, and personal care and supervision. The findings are: A. Based on observations, interviews, and record reviews the facility failed to maintain the facility in a clean and orderly manner free of obstructions and hazards in regards to bed bugs (rooms #5, #11, #14, #15, #22, #23, #28, #38, a common area next to room #3, and the snack room). [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].	D912		

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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
D912	Continued From page 26 B. Based on observations, interviews, and record reviews the facility failed to provide adequate supervision at meals to prevent residents (Resident #4) from eating after another resident (Resident #5) who had a communicable disease. [Refer to Tag 270, 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (Residents #5) were free of neglect related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure health care needs were met for 1 of 5 sampled residents (#5) as related to failure to contact the dentist for a resident (#5) who was experiencing tooth pain, bleeding gums and difficulty eating because of broken teeth over the past three months and had not seen a dentist in almost 2 years. [Refer to Tag 273, 10A NCAC 13F .0902 (b) Health Care (Type B Violation)].	D914		