Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092186	A. BUILDING: ______ B. WING ______	R 10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF GARNER	1437 AVERSBORO ROAD GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on October 17-19, 2017.	{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, ceilings, and floors were kept clean and in good repair for 15 resident rooms, the East and West hallways, the common day room on the West hall, the common living room on the West hall, and the outdoor smoker's area of the facility. The findings are: Observation of the East Hall on 10/17/17 at 11:06am revealed there was an exit door to the left of the dining room entrance that had black and gray dirt buildup below the level of the door knob extending the entire width of the door. Observation of the outside smoker's area on 10/17/17 between 11:15am and 11:21am revealed: -There was an outdoor concrete walkway approximately 100 feet in length extending from the dining room of the cafeteria to an entrance	{D 074}		

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into the West Hall of the facility.
-There were 6 residents observed smoking along the walkway.
-There were approximately 50 cigarette butts in an 8-foot square area on the concrete patio by two chairs, against the brick wall immediately exiting the right wall cafeteria exit door of the facility.
-There were approximately 40 cigarette butts by the chair next to an air-conditioning unit on the ground next to a cigarette waste receptacle.
-There was an empty styrofoam cup in the middle of the walkway that had spilled and had 8 cigarette butts around the cup.
-There was a cigarette disposal receptacle by the West Hall entrance with approximately 100 cigarette butts around the base of the receptacle and in the flower bed behind the receptacle.

Observation of the West Hall living room on 11/17/17 at 11:23am revealed there were multiple dark brown stains on the light brown carpeting throughout the entire room.

Confidential interviews with 4 residents revealed:
-Residents typically tossed their used cigarettes on the ground despite the cigarette butt disposal receptacles.
-Staff rarely swept the walkway to remove the used cigarette butts.
-The receptacles were placed too far from the chairs where residents smoked.
-Staff never enforced the use of the receptacles.
-Resident's expected the facility staff to clean the walkways and encourage those residents who were non-compliant in using the receptacles.

Observation of the West Hall common day room on 10/17/17 at 12:30pm revealed:
-There were multiple dark brown stains on the

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linoleum floor to the right of the vending machine.
-The entry door had horizontal scrapes at the base of the door extending the entire width.
-The entry door had an approximately 12-inch long scrape below the dart board on the back of the door.
-The ceiling vent was rusted to the left of the door.

Observation of the East Hall on 10/17/17 from 11:00am - 1:00pm revealed:
-There were scuff marks and scrapes in the wood across the lower 2-1/2 feet of the doors of resident rooms #313, #314, #316, #317, #321, #324, #322, #329, and #331.
-The hallway carpet had dark brown stains.
-The 6-foot long floor registers had missing paint, dark brown and tan spots on the top edge, and a coating of gray dust along the front side vent spaces.
-The hallway floor wood molding had white specks and dark brown stains.
-The upper edge of the floor's flexible brown molding had detached from the wall in 1-1/2-foot sections along the hallway.

Observation on 10/17/17 at 11:44 am of resident room #321 revealed:
-The bottom molding strip along the baseboard was missing on the right wall exposing a 1-inch wide dark brown sticky substance on the linoleum flooring.
-The linoleum flooring had yellow-brown smudges and drops of white paint along the floor next to the walls.
-There were brownish-black smudges on the front and along the sides and bottom edges of the closet door.
-There was a black substance on the bottom of the closet door frame and floor molding on each

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side of the closet door.
-The closet door hinges were rusted and had missing paint.
-The back right corner of the room flooring was missing a 2-1/2 foot square section of linoleum exposing the concrete subflooring that had a dark brown build-up of dirt and dust.
-There was missing paint on the cinder block wall behind the bed and white paint splatters on the linoleum flooring.
-There were black smears on the wall above the resident's bed headboard.

Observation of resident room #313 on 10/17/17 at 11:47am revealed:
-The inside bottom 2-foot edge of the door had a 1-inch scrape mark across the width of the door.
-There were brownish-black smudges on the bottom 2 ' of the door.
-There were dark brown and yellow-brown smears on the room walls.
-There were dark brown and yellow-brown stains on the linoleum flooring.

Observation of resident room #319 on 10/17/17 at 12:00pm revealed the top edge of the floor molding was detached from the right wall making an open pocket above the base of the wall.

Interview with the resident in room #319 on 10/17/17 at 12:00pm revealed:
-The floor molding was loose from the wall by the entry door.
-There were no maintenance staff at the facility.
-The maintenance staff quit in the middle of July 2017.
-The facility had not hired replacement maintenance staff.
-The resident wiped dust off of the upper wall air conditioning unit daily to keep it clean.

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Observation of resident room #316 on 10/17/17 at 12:08pm revealed:
-The linoleum flooring in the closet had black-brown stains and was missing a 2-inch by 3-inch section of subflooring
-The floor at the base of the door frame had a build-up of dark brown dirt and small crumbs.

Observation of resident room #311 on 10/17/17 at 12:57pm revealed:
-There were thin black smears on the walls at the corners of the room by the window.
-There was brownish-black dirt build-up at the base of the floor molding all around the room.
-The electrical outlet and lamp cord beside the resident's bed were coated with a yellowed dust.
-The wall on the hallway side had brownish-black scuff marks across the width of the entire wall extending 3-feet from the floor.
-There were loose linoleum tiles with curling edges bordering the wall edge beside the door.

Observation of the West hallway on 10/17/17 from 11:00 am - 1:00 pm revealed there were scuff marks and scrapes in the wood across the lower 2 1/2 feet of the doors of resident rooms #119, #117, #115, #114 #113, #112, #110, #109, #108, #106, #104, #102, #99, and #97.

Observation of resident room #114 on 10/17/17 at 11:08am revealed:
-There was white paint peeling from a 1 1/2-foot long section above the baseboard of the wall next to door entrance.
-The was a horizontal gray scrape mark on the wall next to the second closet door that measured approximately 2 feet long.
-The panel of the electrical outlet by the second closet door was cracked and pushed in slightly.

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-There were several black stains and black marks scattered across the floor.
-There was wax build-up around the perimeter of the floor in the room.

Interview with the resident in room #114 at 11:08am revealed:
-The paint had been peeling and the electrical outlet had been cracked for several months.
-She could not specify the length of time the peeling paint and cracked electrical outlet had existed.
-She had not complained to any staff about the peeling paint or the cracked electrical outlet.
-She did not know anything about the wax build-up or the scrape on the wall.
-Staff damp mopped the floor in her room every day.

Observation of resident room #112 on 10/17/17 at 11:15am revealed:
-There were four of four walls that had numerous clear and gray drip stains, black marks, scrape marks, and peeling gray paint.
-There was brown wax build-up around the perimeter of the floor in the room.
-There were numerous black stain marks scattered across the floor.
-There was a 4-inch hole with cracked tan putty inside the interior of the hole in the first closet door.

Observation of the hallway area outside of resident room #117 on 10/17/17 at 11:30am revealed there were two areas of exposed white baseboard with peeling tan paint that measured approximately 2 feet wide by 5 inches long and 8 inches wide and 1 foot long.

Observation of Room #106 on 10/17/17 at

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12:34pm revealed 3 rust-colored stained linoleum tiles in front of the night stand.

Interview with a resident in resident room #117 on 10/17/17 at 11:35am revealed she had not noticed the exposed white baseboard in the hallway.

Observation of resident room #115 on 10/17/17 at 11:42am revealed:
-There were four of four walls with black scrape marks, black stains, and gray drips stains were scattered throughout the room.
-There were scattered white stains on the blue carpet on the left side by the door entrance.
-The entrance door into the room and the door frame had several horizontal scrape marks to the lower third area of the door and door frame.

Observation of resident room #113 on 10/17/17 at 11:54am revealed:
-Four of four walls had various black scrape marks, black stains, and gray drip stains in all areas.
-There were black stains and black scuff marks on the floor around the perimeter of the room.
-The floor was sticky when staff walked across it.

Observation of resident room #108 on 10/17/17 at 12:05pm revealed:
-The wall on the left side of the door entrance had several black scrape marks.
-There was a black stain that measured approximately 2 inches wide by 1 1/2 inches long located 2 inches above the light switch in the room.
-There was a hole in top half the 1st closet door that measured approximately 1 inch wide and ½ inch long.

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Observation of resident room #109 on 10/17/17 at 12:10pm revealed an 8-inch long section of blue carpet located at the door entrance that was frayed.

Interview with a resident in resident room #109 on 10/17/17 at 12:10pm revealed:
-The carpet had been frayed for a couple of weeks (exact time was not specified).
-Staff was supposed to fix the carpet but she could not recall the staff person's name.

Observation of the common living room on the right side of the West Hall on 10/17/17 at 12:20pm revealed:
-Four of four walls had scattered black scrape marks and stains.
-Four of four baseboards had scattered black scrape marks and stains.

Observation of the common living room on the left side of the West Hall on 10/17/17 at 12:30pm revealed:
-There were several brown stains on the ceiling area.
-Both ceiling air vents to the left ceiling areas had scatted rusted areas.

Observation of resident room #103 on 10/17/17 at 12:35pm revealed that four of four walls had black stains, black marks, and gray drips scattered on all of the walls.

Observation of the right side entrance of the dining room on 10/17/17 at 12:44pm revealed the lower third of the door frame of the entrance had several black and gray scrape marks.

Observation of the dining room on 10/17/17 at 12:48pm revealed:

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-Four of four walls had several scattered black and gray scrape marks.
-A 4 inch by 3 inch rectangular piece of tile was missing from the flooring next to the exit door for the smoking area inside the dining room.

Confidential interview with a maintenance contractor revealed:
-He was part of a 3-person team that painted many of the owner's facilities.
-They painted 3 days per week at the facility.

Confidential interview with 3 staff revealed:
-The facility did not have a maintenance person.
-The facility contracted an outside maintenance company.
-They were unable to comment about ongoing repairs at the facility.

Interview with the Administrator and Regional Director on 10/19/17 at 2:25pm revealed:
-The facility was currently making repairs and repainting the entire building.
-The painters had been in the building every day for the last 15 days.
-They would make note of anything brought to their attention in need of repair.
-They could not give a completion date for the painting or repairs needed at the facility.
-They did not provide an answer for the past repairs or painting needs not being completed.

D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings	D 076		

10A NCAC 13F .0306 Housekeeping And Furnishings
(a) Adult care homes shall:
(3) have furniture clean and in good repair;

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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 ensure the furniture was kept clean and maintained in good repair.

The findings are:

Observation of resident room #114 on 10/17/17 at 11:08am revealed:
-The headboard of the resident's bed was covered with gray stringy dust.
-There was a 6-drawer dresser with a broken handle to the left middle drawer and a missing knob on the top right drawer.
-The wooden legs and wooden leg supports of a green vinyl chair had several scrape marks.

Interview with resident in room #114 at 11:08am revealed:
-She had not complained to any staff about dusty headboard, dresser handles, or scraped chair legs because she had not noticed it.
-She could not specify how often her room was cleaned by housekeeping.

Observation of resident room #117 on 10/17/17 at 11:35am revealed a knob was missing from the top right drawer and there were several scrape marks on the front of the 6-drawer dresser in the room.

Interview with a resident in resident room #117 on 10/17/17 at 11:35am revealed:
-The knob on the dresser had been missing for about a year.
-She had not complained about the missing knob because she could still open the dresser drawer.

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D 076	Continued From page 10 -She was not sure how long the scrape marks had been on the dresser. Observation of resident room #115 on 10/17/17 at 11:42am revealed: -There was a 2-drawer nightstand with a knob missing from the top drawer and with several scrape marks on the front of the night stand. -The top ledge of the headboard was missing. -The wooden legs and wooden leg supports of a burgundy vinyl chair had several scrape marks. -The corner of the right armrest of the burgundy vinyl chair was cracked. -A 6-drawer dresser had several scrape marks across the front side of the dresser and a handle was missing from the 2nd drawer on the right side. Observation of resident room #113 on 10/17/17 at 11:54am revealed: -Both knobs were missing from the top drawer of a 2-drawer nightstand sitting next to the bed. -A second 2-drawer nightstand located next to the 1st closet door on the right side of the room was missing a knob to the top drawer. -A 6-drawer dresser had a missing knob on the top drawer on the right side. -The wooden legs and wooden leg supports of a green vinyl chair had several scrape marks. Observation of resident room #108 on 10/17/17 at 12:05pm revealed: -There was a 3-drawer dresser that had a missing left handle to the middle drawer. -The top drawer of a 2- drawer nightstand sitting next to the bed was missing a knob from the top drawer. -The wooden legs and wooden leg supports of a green vinyl chair had several scrape marks.	D 076		

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Observation of resident room #109 on 10/17/17 at 12:10pm revealed:
-There was a 6-drawer dresser that had a missing handle to the middle drawer on the right side and had several scraped areas on the front side of the dresser.
-The wooden legs and wooden leg supports of a burgundy vinyl chair had several scrape marks.

Observation of the common living room on the right side of the West Hall on 10/17/17 at 12:20pm revealed:
-A burgundy loveseat on the right side of the room had worn seat cushions and brown stains on both armrests.
-There was a 6-inch area of fabric that was ripped from the lower left corner of the loveseat extending to the left leg support.
-A burgundy sofa on the right side of the room had worn seat cushions, two worn armrests, and exposed white batting along the bottom on the front side of the sofa.
-A second burgundy sofa on the left side of the room had worn seat cushions with several white stains, two worn armrests, and exposed white batting along the bottom on the front side of the sofa.
-A second burgundy loveseat on the left side of the room had worn seat cushions, two frayed throw pillows, two worn armrests, and exposed white batting along the bottom on the front side of the loveseat.

Observation of the common living room on the left side of the West Hall on 10/17/17 at 12:30pm revealed there was brown curio stand with thick brown dust on its shelves.

Observation of resident room #103 on 10/17/17 at 12:35pm revealed:

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-There was a 6-drawer dresser with a missing knob to the top drawer on the right side and a missing knob to the top drawer on the left side.
-The front side of the dresser had several scraped areas to the front side of the dresser.
-There was a 2 drawer nightstand with a missing knob from the top drawer and the front side of the nightstand had several scraped areas.

Observation of resident room #102 on 10/17/17 at 12:40pm revealed:
-There was a burgundy vinyl chair with several gray stains on the back cushion and several scrape marks to all of the wooden legs and wooden leg supports.
-There was a second burgundy vinyl chair with several scrape marks to all of the wooden legs and wooden leg supports.
-A 6-drawer dresser had a missing handle to the middle drawer on the left side.

Confidential interview with 3 staff members revealed:
-The facility did not have a maintenance person.
-The facility contracted an outside maintenance company.
-They were unable to comment about ongoing repairs at the facility.
-No response was given when asked about needed repairs at the facility.

Interview with the Administrator and Regional Director on 10/19/17 at 2:25pm revealed:
-The facility's focus was to make repairs and repaint the entire building.
-They could not provide a timeframe for the completion of the repairs and painting.
-They were both unaware of the condition of the sofas in the living room and the broken furniture in the resident rooms.

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D 076	Continued From page 13 -The Administrator was constantly replacing knobs on all of the dressers and nightstands. -They would make note of anything brought to their attention in need of repair. -They could not give a completion date for the repairs needed at the facility.	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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to assure the residents' rooms and common areas were free of hazards as evidenced by the presence of bed bugs, roaches and flies in the residents' rooms and dining room. The findings are: Observation of the dining room on 10/17/17 between 11:07am - 11:09am revealed:	{D 079}		

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{D 079}	Continued From page 14	{D 079}		

-There were three rows of tables.
-The first table on left wall row had a live fly on the table.
-The second table on the right wall by the exit door to the smoker's area had 2 live flies on top of the table.
-The third table by the right wall had a live fly on top of the table.
-There was a live fly on the last table by the right wall.

Observation of the dining room table to the left of the kitchen door at 10/17/17 at 11:10am revealed:
-There was a live fly on a brown tray containing 8 glass containers labeled sugar and creamer.
-All glass containers had metal dispensing flaps in the open position with sugar granules present around the flaps on 4 of the 8 metal lids.

Observation of resident room #216 on 10/17/17 at 12:01pm revealed there were two dead crushed roaches on the floor by the right wall 2-feet from the entrance of the resident room.

Observation of resident room #217 on 10/17/17 at 12:04pm:
-There were multiple remains of bug parts and red spatter on the concrete wall section directly above the bedspread and below the air-conditioner located near the ceiling corner in an area approximately 4 feet by 4 feet.
-There were two live bed bugs under center wooden frame of the air-conditioner in the concrete wall's crevices.
-There were 2 live bed bugs above the headboard at the ceiling corner.
-There was a 2-inch by 0.5-inch red stain in the center of the pillow case on the bed.
-There was a 4-inch long light red stain in the center of the pillow case's other side.

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{D 079}	Continued From page 15	{D 079}		

Observation of resident room #117 on 10/17/17 at 11:35am revealed a 10 ounce box of mothballs was sitting on the dresser.

Interview with a resident in resident room #117 on 10/17/17 at 11:35am revealed:
-The box of mothballs belonged to the resident.
-She used the mothballs in her dresser to keep the roaches away.
-She saw both baby and adult roaches in her room approximately 3-4 times a day.
-She did not like seeing the roaches in her clothes so she put mothballs inside the drawers of the dresser.
-The facility was sprayed for roaches about every 2 weeks.
-She had not complained about the roaches in her room because the facility was already being sprayed for roaches.

Interview with the resident that resided in resident room #217 on 10/17/17 at 12:07pm revealed:
-The Administrator was notified that his resident room had bed bugs approximately 1 month ago.
-The Administrator told him that the resident room could not be sprayed due to the resident's room being congested, specifically the dresser was too bulky to be moved.
-The inability to move the dresser prevented the room from being treated for bed bugs.
-There were 3 bed bugs on the wall on 10/16/17 at approximately 9pm that he was unable to "mash" because they were "crawling beyond reach."
-The wall by the bed was stained with red blood from the "daily mashing" of bed bugs with his own fingers.
-The staff regularly changed his sheets but could do nothing about the bed bugs.

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-He told the staff previously about bed bugs in his resident room but could not recall exact dates.
-He wanted his resident room to be treated for bed bugs.
-He did not request to be moved to another room.
-He did not recall being offered to be moved to another room.
-Roaches could often be see every morning but would disappear into the brown rubber baseboard lining when the lights were turned on.
-He was more concerned about the bed bugs than roaches.

Confidential interview with a resident revealed:
-Several residents had been moved from their resident rooms on the same hallway as the resident in room #217 because of bugs.
-Bed bugs were seen in their resident room even after the pest control company sprayed in September 2017.
-The resident had been moved to another resident room after a visiting family member had killed 3 bed bugs crawling on the resident's pillow approximately 3 weeks ago and reported it to the Administrator.
-The visiting family member had moved the mattress and discovered multiple bed bugs near the headboard.

Confidential interview with a family member:
-She was visiting her family member who resided in the facility.
-She had killed a bed bug on the resident's pillow in their room during a visit in September 2017.
-Upon moving resident's mattress, she found several bed bugs and began "smashing them."
-She insisted that the resident be moved and that the resident room be treated.
-Her husband inspected the room during their visit had found additional bedbugs in a picture

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frame in the resident room.
-The resident had not complained of bed bugs since the room change.

Confidential interview with a second resident revealed:
-The facility pest control people were seen in the building about once per month.
-The pest control people did not mention the types of pests they were spraying for at the facility.
-The rooms being treated were recently vacated resident rooms.
-The pest control people sprayed only certain resident rooms on each monthly visit.
-The facility was not able to control the roach population "because they run behind the base boards in every resident room when you turn on the lights."
-Several resident rooms had their belongings "packed up" and were taken to be cleaned.
-Some resident rooms that were treated after removing the resident's belongings were allowed to go back into the same resident room after treatment, other residents were moved after treatment to another resident room.
-The facility's problem with flies improved since July 2017.
-The facility's roach problem was the same since July 2017.
-The bed bugs were still a problem at the facility but the facility kept moving residents from resident room to resident room when bed bugs were discovered.

Confidential interview with a third resident revealed:
-She saw roaches every morning in her room when she turned on the lights.
-On 10/18/17, the residents were told they could

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not go into the cafeteria after lunch because they were spraying for roaches.
-There was a roach approximately 2-inches in length above the archway entrance of the cafeteria on 10/17/17 during lunch.
-The problem with roaches had not improved since July 2017.
-The problem with flies in the facility improved since July 2017.
-The bed bug problem in the facility was a constant issue but the resident rooms identified has having bed bug activity kept changing.

Confidential interview with a maintenance contractor revealed:
-He had not seen any live bed bugs at the facility.
-He had seen dead bed bugs at the facility as well as other dead pests.
-He was seeing unknown bugs in the crevices of the concrete wall and painted over them.
-Painting over a live bugs would suffocate them instantly.
-The painters were putting two coats on each wall.
-He had not reported seeing any live or dead pests to any staff at the facility.

Observation of resident room #204 on 10/17/17 at 12:09pm revealed:
-There was a live fly on the resident's arm as he slept.
-There were 3 red round stains approximately 0.25-inches in diameter on the white top sheet on the mattress.
-There were 6 round red spots in a row on the bed sheet on the side of the mattress.
-There was a dead bed bug on the underside of the comforter that was folded over on the resident's bed.
-There were 5 red spots next to each other in the

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center of the resident's pillow case.
-There were 3 dead bed bugs on the floor by the headboard of the bed.
-There was a live spider in a web in the corner to the left of the entry door.

Observation of resident room #206 on 10/17/17 at 12:18pm revealed:
-There were 3 red spots in a row on the white bed sheet in the center of the bed.
-There was a live bed bug on the floor between the wooden headboard leg and the metal box spring support leg.
-There were no residents in the resident room.

Observation of resident room #207 on 10/17/17 at 12:19pm revealed:
-The gray plastic border of the mattress at the top center had red smear marks extending 3 inches in length.
-There were 3 non-moving tiny bed bugs in the gap next to the red smear marks.

Observation of the West Hall women's bathroom revealed 2 drain flies on the wall over the safety railing on the left wall.

Observation of resident room #97 on 10/17/17 at 12:42pm revealed:
-There were multiple red spots on top of the mattress.
-There were 5 dead bed bugs in the seams on the right upper middle of the mattress.
-There was a brown wig at the floor wedged between the headboard and the wall.

Observation of resident room #98 on 10/18/17 at 8:24am revealed:
-There were 5 live roaches on the right rear corner of the night stand.

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-There was one live roach above the outlet on the wall behind the night stand.
-The resident was asleep in the resident room.
-There was a dead bed bug on the floor by the middle of the bed.

Interview with the resident in room #329 on 10/17/17 at 11:00am revealed:
-There had been bed bugs and roaches in her room before the "bug man" came 2 weeks ago (did not remember the date) and sprayed the room.
-The resident in room #329 had not seen any "bugs" since the room was sprayed.

Interview with the resident in room # 324 on 10/17/17 at 11:25am revealed:
-His room was sprayed last week (did not remember the day) for bed bugs, roaches, and flies.
-He had not seen any bugs in his room since then.

Observation of resident room #323 on 10/17/17 at 11:36am revealed:
-There was one dead roach on the floor located 1-inch away from the floor molding by the inside of the doorway.
-At the lower 8 inches of the hinge side of the door frame were 3 live roaches huddled together, 1 live roach 2 inches below the other 3, and 7 small dead roaches.
-There was a live roach crawling down the back wall of the closet.
-There was a dead roach laying on the closet floor.

Interview with the resident in room #319 on 10/17/17 at 12:00pm revealed:
-He saw 2 live roaches yesterday (10/16/17) on

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the side wall across from his bed,
-There had been bed bugs in his room; the room was sprayed yesterday, he had not seen bed bugs today.
-There had been pesticide sprayed in his room 4 days before yesterday.
-The floor molding was loose from the wall, roaches could live in there.
-The resident believed there were roaches were still hiding in his room because he saw some smaller ones this morning on the wall (did not remember what time).

Observation of resident room #319 on 10/17/17 at 12:15pm revealed:
-There was a live roach on the back wall of the closet.
-There was a live roach crawling on the wall above the the resident's bed headboard.

Observation of resident room #316 on 10/17/17 at 12:08pm revealed there was a live roach on the right side wall of the resident's closet.

Observation of of resident room #98 on 10/18/17 at 7:59am revealed:
-The resident was asleep in her bed.
-There was a small chest of drawers against the wall located 2 feet away on the right side of the resident's bed.
-There was a live roach at the top of the electrical outlet cover visible above the chest of drawers.
-At the corner, on the back side of the chest, were 3 live roaches huddled together.

Interview with the Regional Director while in room #98 on 10/18/17 at 8:30am revealed:
-She "would get right on that" upon seeing the roaches on the chest of drawers.
-She would not say whether the resident room

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had been sprayed in the past.
-She provided no further comment or information.

Review of the facility-provided pest control receipts on 10/18/18 revealed:
-The facility provided 3 sheets with 3 dates of treatment.
-The facility was treated for roaches, bedbugs and household pests on 8/15/17
-The facility was treated for bedbugs and household pests on 9/19/17 and 10/13/17.
-There were no resident room numbers or areas of treatment indicated on the receipts.
-Each receipt had a page number at the bottom of indicating that it was only page #3.

Interview with the Regional Director on 10/18/17 at 9:05am revealed she was not permitted to give the receipt pages that described what resident rooms or areas of the facility were treated.

Interview with the Vice President of Residential Communities (VPRC), the Regional Director and telephone interview with the owner of the facility on 10/18/17 at 9:30am revealed:
-They would not confirm or deny any presence of bed bugs, roaches or other pest activity in the facility.
-They would not provide information related to which areas of the facility were treated for bed bugs or roaches.
-They did not believe that there were any live bed bugs in the facility.
-The pest control company sprayed monthly to ensure there were no pests in the facility.
-They trusted the pest control company to evaluate and determine any resident rooms in need of spraying.
-If the pest control company found bed bugs they would spray those particular resident rooms if

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they existed.

Confidential interview with two staff members revealed they would not comment on pest control activity at the facility.

Observation of resident room #217 at 9:45am revealed a live bed bug over the headboard on the concrete wall.

Interview with the VPRC at the entrance of the office she was occupying across from the conference room while showing her a live bed bug discovered in resident room #217 on 10/18/17 at 9:50am revealed she did not want to discuss the live bug or acknowledge its presence.

Attempted telephone interview with the facility's pest control company on 10/18/17 at 2:25pm was unsuccessful.

Request for a bed bug cleaning protocol on 10/19/17 at 9:30am was not provided by the facility by end of survey.

Interview with the Regional Director and the Administrator on 10/19/17 at 2:45pm revealed:
-The new post bed bug protocol was to use dishwashing liquid on any mattresses with bed bug activity.
-No further information was provided relating to frequency of dishwashing liquid or other protocols post pest control treatment.
-There was no response when asked which rooms had mattresses that were being wiped down with dishwashing liquid.

Confidential interview with 3 staff revealed:
-They could not confirm or deny any bed bug or roach activity.

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{D 079}	Continued From page 24 -They referred all questioning to their manager. -They did not explain the post bed bug treatment protocol. -They could not explain why resident room #97 had dishwashing liquid on the mattress and box spring. -They did not identify which rooms had been treated by the pest control company. --- The facility failed to ensure the residents environment was free from roaches, flies and bed bugs, and the continued bed bug infestations and staff's lack of knowledge of bed bug protocols was detrimental to the health and safety of the residents. This constitutes a Unabated Type B Violation. --- Review of the facility's Plan of Protection dated 10/19/17 revealed: -Maintain the current contract with a pest control company to treat pests by providing monthly and non-scheduled treatments determined by the pest control company. -Follow the pest control company procedures including immediate cleaning and treatment upon bed bug sightings. -The Regional Director/Administrator shall continue to monitor compliance of the facility's bed bug procedures with random weekly inspections as of 10/19/17. -Staff will continue to report sightings of pests when observed and report to the Administrator and/or Resident Care Coordinator.	{D 079}		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives	D 482		

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(a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:
(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;
(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
(3) the least restrictive restraint that would provide safety;
(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an

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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
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environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

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

Based on observations, interviews, and record reviews, the facility failed to assure geri-chairs were used for safety for 3 of 3 residents sampled (#4, #7, #8) by ensuring restraint assessments and care plans were completed.

The findings are:

1. Review of Resident #4's current FL-2 dated 9/26/17 revealed:
-Diagnoses included dementia without behaviors, history of falls, dysphagia, major depressive disorder, essential hypertension, history of transient ischemic attack, and prosthetic nervous system disorder.
-Resident #4 was non-ambulatory and used a geri-chair.
-Resident #4 was constantly disoriented.
-Resident #4 required assistance with bathing, feeding, and dressing.
-The section for restraints contained no information.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 10/23/11.

Review of Resident #4's current resident care plan dated 9/26/17 revealed:
-Resident #4 was always disoriented and had

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D 482	Continued From page 27 significant memory loss. -Resident #4 had limited strength to upper extremities. -Resident #4 was non-ambulatory and used a geri-chair. -Staff pushed Resident #4 in the geri-chair for all meals, snacks, and activities of daily living. -Resident #4 required limited assistance with eating. -Resident #4 was totally dependent for toileting, ambulation, bathing, dressing, and grooming. -Resident #4 required extensive assistance with transferring with one on one staff for safety. Review of Resident #4's Licensed Health Professional Support (LHPS) review dated 8/4/17 revealed: -It was completed by a registered nurse. -LHPS tasks included ambulation with assistive device, transferring, repositioning every 2 hours, and other prescribed physical therapy. -Resident #4 used a geri-chair for ambulation and required extensive assistance with transfers by staff. Observation of Resident #4 on 10/17/17 at 12:55pm revealed: -Resident #4 was sitting in the dining room in her geri-chair reclined at an approximately 40 degree angle with her feet elevated awaiting feeding assistance. -A black gel cushion was in the geri-chair seat under Resident #4. -There was blue cushion in the geri-chair behind the back of Resident #4. -Resident #4 had a large purple colored bruised swollen area in the middle of her forehead and the bruising extended down into the bridge of her nose. -Resident #4 was able to point using her right arm	D 482		

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and hand.
-Resident #4 required assistance with feeding from staff.

Based on observation, interview, and record review, Resident #4 was not interviewable.

Review of a physician consultation report for Resident #4 dated 6/30/17 revealed:
-Resident #4 had dementia and had a history of falls.
-Resident #4 needed a geri-chair for safety.

Review of resident records for Resident #4 on 10/18/17 revealed:
-There was no physician's order for a geri-chair for Resident #4.
-There was no assessment by the physician for the use of a geri-chair by Resident #4.
-There was no medical diagnosis for the use of a geri-chair by the physician for Resident #4.
-There was no consent for the use of a geri-chair for Resident #4.

Interview with a personal care aide (PCA) on 10/17/17 at 12:58pm revealed:
-Resident #4 required assistance with all of her activities of daily living.
-Resident #4 had been in a geri-chair for about two months due to frequent falls from her wheelchair.

Interview with family member for Resident #4 on 10/18/17 at 2:57pm revealed:
-Resident #4 had fallen from her wheelchair about a month or two ago.
-The family member had asked the facility if Resident #4 could be restrained but he was told no.
-He could not specify whom he had spoken with.

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-The family member did not know what else to do because he did not want Resident #4 to get hurt falling out of her wheelchair.
-The family member spoke with someone at the durable equipment store and the geri-chair was suggested to keep Resident #4 from falling.
-The family member had purchased the geri-chair for Resident #4 to prevent any further falls due to Resident #4 tilting forward out of her wheelchair.
-The family spoke with Resident #4's physician and got an order for the geri-chair.
-The family member did not think Resident #4 could get out of the geri-chair if it was reclined.
-Resident #4 did not have the strength to get the geri-chair out of a locked reclined position.
-It was expected for geri-chair to be reclined because it kept Resident #4 confined and it was impossible for her to get up without assistance.
-The family member did not know how often staff monitored Resident #4 when she was in her geri-chair.

Interview with a medical assistant with the primary care physician's office on 10/18/17 at 3:30pm revealed:
-Per an office note dated 6/30/17, Resident #4 was already in a geri-chair when a family member brought her in for that office visit.
-Family member said the geri-chair kept Resident #4 more secure and in a position to keep her from falling.
-The primary care physician wrote an order for a geri-chair for Resident #4 on 6/30/17.
-Resident #4 needed to be reclined while in the geri-chair and not sitting upright while in the geri-chair to prevent falls.
-There had been no request for a restraint assessment from the facility prior to Resident #4's office visit on 6/30/17.
-There had been no request for a restraint

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D 482	Continued From page 30 assessment from the facility since 6/30/17. Interview with the Resident Care Coordinator (RCC) and medication aide (MA) on 10/18/17 at 12:33pm revealed: -Resident #4 used a geri-chair. -Resident #4 would not be able to adjust the chair with staff assistance. -Resident #4 would not be able to get out of the geri-chair in the reclined position. -The Resident #4's family member purchased the geri-chair. -Staff checked Resident #4 every 2 hours. Interview with the RCC on 10/18/17 at 3:45pm revealed she was unable to locate the physician's order for the geri-chair for Resident #4. Interview with the Regional Director on 10/19/17 at 12:13pm revealed: -The Regional Director stated, "Resident #4 used her geri-chair for comfort and her family wanted to keep Resident #4 from falling out of her wheelchair." -The Regional Director reported that Resident #4 had a physician's order for the use for geri-chair for "safety". Refer to interview with the Regional Director and Administrator on 10/19/17 at 12:13pm. Refer to interview with the Regional Director on 10/19/17 at 2:17pm. 2. Review of Resident #8's current FL-2 dated 7/6/17 revealed: -Diagnoses included gastrointestinal hemorrhage, Vitamin D deficiency, cerebral infarction, pressure ulcers on the buttocks, and dementia. -Resident #8 was non-ambulatory and used a	D 482		

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geri-chair.
-Resident #8 was intermittently disoriented.
-The section for restraints contained no information.

Review of Resident #8's Resident Register revealed the resident was admitted to the facility on 11/2/15.

Review of Resident #8's current resident care plan dated 12/21/16 revealed:
-Resident #8 was always disoriented and had significant loss.
-Resident #8 had limited strength to upper extremities.
-Resident #8 was non-ambulatory and used a geri-chair.
-Resident #8 required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #8's Licensed Health Professional Support (LHPS) review dated 9/5/17 revealed:
-It was completed by a registered nurse.
-LHPS tasks included ambulation with assistive device, transferring, and range of motion exercise.
-Resident #8 required staff assistance with ambulation and transfers.
-Resident #8 had a geri-chair for mobility.

Observation of Resident #8 on 10/18/17 at 12:50pm revealed:
-Resident #8 was sitting in the dining room awaiting to be fed in his geri-chair reclined at an approximately 45 degree angle with his feet elevated.
-Resident was being fed by staff.

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D 482	Continued From page 32 Based on observation, interview, and record review, Resident #8 was not interviewable. Review of resident records for Resident #8 on 10/18/17 revealed: -There was no physician's order for a geri-chair for Resident #8. -There was no assessment by the physician for the use of a geri-chair by Resident #8. -There was no medical diagnosis for the use of a geri-chair by the physician for Resident #8. -There was no consent for the use of a geri-chair for Resident #8. Interview with the Resident Care Coordinator on 10/19/17 at 10:40am revealed: -She did not know where the order for the geri-chair for Resident #8 came from but it may have come from hospice. -She would have to look through Resident #8's older records to find the geri-chair order. -She could not verify how long Resident #8 had a geri-chair. Interview with family member for Resident #8 on 10/19/17 at 2:15pm revealed: -Hospice had gotten the order for the geri-chair for Resident #8 for safety reasons due to previous falls from his wheelchair. -The family member believed Resident #8 got his geri-chair during this past summer but she could not specify which month. -The family member was not sure if Resident #8 could get out of the geri-chair when it was reclined without assistance. -The family member did not consider Resident #8's geri-chair to be a restraint in a reclined position. Attempted interview with Resident #8's primary	D 482		

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care physician was unsuccessful on 10/19/17 at 2:30pm.

Interview with the hospice care manager for Resident #8 on 10/19/17 at 2:35pm revealed:
-The order for Resident #8's geri-chair was written by their medical provider either in June 2017 or July 2017.
-There had been a malfunction with their documentation software and all orders from June and July 2017 had been lost.
-She re-wrote the geri-chair order on 10/19/17 and faxed it to the facility.
-The facility had requested the order for the geri-chair sent on 10/19/17.
-The order for the geri-chair was written for safety issues for fall prevention.
-Their medical provider did write orders for geri-chairs but their office didn't provide any restraint orders or assessments for Resident #8.
-The facility had not contacted them for any restraint orders or assessment for Resident #8.

Interview with the Regional Director and Administrator on 10/19/17 at 12:13pm revealed she was not sure why Resident #8 used a geri-chair.

Refer to interview with the Regional Director and Administrator on 10/19/17 at 12:13pm.

Refer to interview with the Regional Director on 10/19/17 at 2:17pm.

3. Review of Resident #7's current FL-2 dated 5/30/17 revealed:
-Diagnoses included dementia without behaviors, muscle weakness, cognitive communications deficit, and depressive disorder.
-Resident #7 had a right above the knee

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amputation and was non-ambulatory.
-Resident #7 was intermittently disoriented.
-Resident #7 needed assistance with bathing, dressing, and incontinence care.
-The section for restraints contained no information.

Review of Resident #7's Resident Register revealed an admission date of 9/13/2012.

Review of Resident #7's current care plan dated 4/18/17 revealed:
-The resident had a significant change; she was released from the hospital with a right above the knee amputation.
-The resident was always disoriented, had significant memory loss, and must be directed.
-The resident was totally dependent on staff assistance for toileting, ambulation, bathing, dressing, and transferring.
-The resident had Licensed Health Professional Support (LHPS) personal care tasks for ambulation and transfers.

Review of Resident #7's Licensed Health Professional Support (LHPS) reviews revealed:
-There was an evaluation by a Registered Nurse (RN) on 6/21/17; there were no tasks checked, but had documentation that the resident required extensive assistance with ambulation and transfers; "resident observed sleeping in a geri-chair in living room".
-There was an evaluation done by an RN on 9/05/17; tasks checked were ambulation using assistive devices and transferring semi- (or) non-ambulatory residents; documentation included "resident is seated in a geri-chair in hallway".

Observation on 10/19/17 at 12:55pm of Resident

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#7 revealed:
-The resident was seated in a geri-chair located in the side dining room having lunch.
-Staff was providing feeding assistance to the resident.

Review of resident records for Resident #7 revealed:
-There was no assessment by the physician for the use of a geri-chair by Resident #7.
-There was no medical diagnosis for the use of a geri-chair by the physician for Resident #7.
-There was no physician's order for a geri-chair for Resident #7.
-There was no consent for the use of a geri-chair for Resident #7.

Based on observation, interview, and record review, Resident #7 was not interviewable.

Interview on 10/19/17 at 3:25pm with Resident #7's Guardian revealed:
-The resident had a wheelchair to sit in after her operation in April, 2017.
-The resident was with Hospice; the nurse suggested the resident might be more comfortable having a geri-chair to sit in.
-The Guardian was not sure if the facility had obtained a physician's order for the geri-chair; he was not sure if the resident's physician had done an assessment of the resident for the use of the geri-chair.
-The Guardian did not know how the process was done, but he knew Resident #7 was supposed to get a geri-chair.
-The Guardian could not recall talking with any staff at the facility about having a geri-chair; he had not thought of the chair as being a restraint.
-Resident #7 would normally be reclining in the chair with the back of the chair angled slightly

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downward; she had not fallen out of the chair; he did not think she could get out of the chair by herself.

Attempted interview on 10/19/17 at 5:50pm with the Hospice nurse was unsuccessful.

Interview on 10/19/17 at 4:05pm with Resident #7's Primary Care Provider's (PCP) office nurse revealed:
-There was documentation for routine visits for Resident #7 on 6/20/17 and 10/03/17; the documentation revealed "patient is thin, frail, sitting in a geri-chair".
-There were no physician notes about obtaining a geri-chair for Resident #7.
-There was no order for a geri-chair for Resident #7.

Attempted interview on 10/19/17 at 4:15pm with Resident #7's physician was unsuccessful.

Attempted interview on 10/19/17 at 4:17pm with Resident #7's nurse practitioner was unsuccessful.

Refer to interview with the Regional Director and Administrator on 10/19/17 at 12:13pm.

Refer to interview with the Regional Director on 10/19/17 at 2:17pm.

____

Interview with the Regional Director and Administrator on 10/19/17 at 12:13pm revealed:
-Regional Director reported the facility was restraint-free.
-The Regional Director reported that a physician's order was needed for a resident to get a geri-chair.
-The facility currently had 3 residents who used

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geri-chairs for safety reasons. .
-The Regional Director and the Administrator did not know if restraint assessments or restraint use orders had been completed for the 3 residents who used geri-chairs.
-The Regional Director reported that the RCC may have gotten orders for restraints use for those 3 residents on yesterday but the geri-chairs were not restraints.
-The Regional Director reported that if an order (for restraints) was implemented, the facility would notify the family and do and nurse assessment and care plan for restraints.

Interview with the Regional Director on 10/19/17 at 2:17pm revealed:
-The RCC contacted the physicians for the new restraint orders (for geri-chair use) on 10/18/17 with instructions that the orders were to be signed and returned to the facility.
-The facility's peer review team saw a need to perform reassessments for the 3 residents in geri-chairs on 10/18/17 because of changes in their conditions.
-The facility was familiar with the needs of Resident #4, #7, and #8.
-She was not familiar with the rule area regarding restraint use.
-She did consider a geri-chair as restraint only if it was in a reclined position.

Review of the facility's restraint policy revealed a restraint will only be applied after an order has been obtained, resident/representative has given consent, and a restraint assessment and care plan have been completed by the collaborative team.

Review of the facility's consent for physical restraint use form revealed examples of restraints

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{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:	{D912}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF GARNER	**1437 AVERSBORO ROAD** **GARNER, NC 27529**

(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 39 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, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to housekeeping and furnishings and the use of physical restraints and other alternatives. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to assure the residents' rooms and common areas were free of hazards as evidenced by the presence of bed bugs, roaches and flies in the residents' rooms and dining room. [Refer to Tag D079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Unabated Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure geri-chairs were used for safety for 3 of 3 residents sampled (#4, #7, #8) by ensuring restraint assessments and care plans were completed. [Refer to Tag D482 10A NCAC 13F .1501(a) Use of Physical Restraints and Other Alternatives (Type B Violation).]	{D912}		