

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/07/2017
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NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2	STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244
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C 000	Initial Comments The Adult Care Licensure Section and the Caswell County Department of Social Services conducted an annual and follow-up survey on 11/07/17.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure floors in the main hallway, living room, dining room and 3 of 4 common bathroom were clean and in good repair. The findings are: Observation on 11/07/17 of resident common bathroom #1 revealed: - At 11:14 a.m., common bathroom #1 revealed the floor in front of the bath tub and along the the base boards of the perimeter had a black/brown colored build-up of dirt. - The floor tiles in the bathroom #1 were stained a brownish color throughout. - At 11:16 a.m., resident common bathroom #2 had a dirty build-up along the perimeter of the room at the base boards. - The floor of the shower had dirt particles and blackish/brown stains. - The tiled area around the commode had a	C 074		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Division of Health Service Regulation

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C 074	<p>Continued From page 1</p> <p>brownish color to the tiles grout between tiles with a brown/black color.</p> <ul style="list-style-type: none"> - Where the smaller commode floor tiles met the bathroom floor larger tiles revealed the floor tiles were cracked and colored a dirty brown color. - There was a thick black build-up of dirt on the floors in the corners. - At 11:17 a.m. resident common bathroom #3 had black and brown smears and stains through out the tiled floor. - There was a thick build-up of black dirt along the baseboards and around the pedestal of the commode. - On the floor was a brownish black ring around the pedestal of the commode and it extended out around the sides and back and front on the floor approximately 3-5 inches. <p>Interview on 11/07/17 at 11:03 a.m. with a resident revealed:</p> <ul style="list-style-type: none"> - He saw floor mopping being done. - He did not know when the floors had been stripped and deep cleaned. - He thought the housekeeping was alright in the facility. <p>Interview on 11/07/17 at 11:30 a.m. with another resident revealed:</p> <ul style="list-style-type: none"> - Staff mopped the floor at night. - He did not know how long the floors had been stained and dirty. - He thought the floors and bathrooms - He was not concerned about the housekeeping in the facility. <p>Observation of the main hallway on 11/07/17 at 12:02 p.m. in front of the sink/cabinets in the hallway revealed:</p> <ul style="list-style-type: none"> - The hallway floor in front of a closet door and the blue and white cabinets and sink area had a 	C 074		

Division of Health Service Regulation

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C 074	<p>Continued From page 2</p> <p>thick black build-up of dirt.</p> <ul style="list-style-type: none"> - The hallway floor in the area in front of the dining room and kitchen had a thick build-up of brown-black dirt. - The kitchen door threshold area had a build up of brown/black dirt. - The floor at both ends of the hallway at the exit doors had a thick black build-up of dirt with smears across the tiles. - The threshold tiles of the floor were cracked with pieces of tile missing. - The corners at each end of the threshold where the walls form a corner, were thick with a black dirty build-up. <p>Observation on 11/07/17 at 12:04 p.m. of the dining room floor revealed:</p> <ul style="list-style-type: none"> - Brownish black stains throughout the tiled floor. - A thick black/brown build-up of dirt was along the baseboards around the dining room. - There were brownish stains on floor tiles in front of the water fountain. <p>Observation of the living room floor on 11/07/17 at 12:06 p.m. revealed:</p> <ul style="list-style-type: none"> - The thresholds to the hallway and the exit door in the living room had a black build up of dirt and black smears on the tiles. - The tile floor had a yellow brownish stained overall color. - The floor of the living room along the baseboards had a black build-up of dirt and brownish stains. - Black smears and marks were on the tiles of the floor in the middle of the living room. <p>Interview on 11/07/17 at 10:00 a.m. with the personal care aide revealed:</p> <ul style="list-style-type: none"> - Daily cleaning included mopping, sweeping, dusting, and cleaning bathrooms. 	C 074		

Division of Health Service Regulation

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C 074	Continued From page 3 - Some of the mopping took place at night. - There was not a specific cleaning schedule. - He was not aware of a deep cleaning schedule but he did pull out beds and clean behind them weekly. Interview on 11/07/17 at 4:38 p.m. with the Administrator revealed: - There was a cleaning schedule. - Staff had different duties to complete. - Staff were to deep clean, strip and buff the floors twice per month. - The cleaning schedule had been modified since he had not been monitoring the cleaning of the facility. - The staff cleaning the floors had been using dirty water to rinse and clean the floors. - He would increase the monitoring of the housekeeping.	C 074		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home 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 homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the resident water fountain and the common resident bath tub was kept in a clean and orderly manner.	C 078		

Division of Health Service Regulation

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C 078	<p>Continued From page 4</p> <p>The findings are:</p> <p>Observation on 11/07/17 at 12:04 p.m. of the resident water fountain in the dining room revealed:</p> <ul style="list-style-type: none"> - The front and sides of the metal water fountain were covered with drink drip marks. - The push handle used to start the water fountain had brownish/black fingerprints and smears. - The vents on the sides had drink spill marks and had a layer of gray dust on the vent slats. - The top metal bowl of the water fountain was covered and stained with dried drink marks, pieces of food spills and dirty gray stains. - Along the dried brown drink stains were particles of a brown material. - There was thick white water stains and build-up along the bowl from the mouth piece to the drain. - There were blue/green water stains from the mouth piece that streaked along the bowl approximately 3-4 inches down toward the drain. - The mouth piece was stained with blue/green water stains, a black mold like substance and brown dirt particles was on and around the area where the water came out of the mouthpiece. <p>Observation on 11/07/17 at 11:30 a.m. a resident was observed bending over drinking water from the dirty mouthpiece.</p> <p>Interview with the resident drinking the water on 11/07/17 at 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> - Residents drank water from the water fountain all of the time. - Some residents poured there coffee and other drinks down the water fountain drain. - He said it had been in the dirty condition like to day for months. - He had not noticed anyone clean the fountain. 	C 078		

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C 078	<p>Continued From page 5</p> <p>Interview on 11/07/17 at 12:05 p.m. with the personal care aide (PCA) revealed:</p> <ul style="list-style-type: none"> - He did not realize it was dirty. - He had worked a short while in the facility. - He had seen residents pour coffee down the fountain drain. - He agreed to put the fountain out of order until thoroughly cleaned. <p>Observation on 11/07/17 at 3 p.m. of the water fountain revealed:</p> <ul style="list-style-type: none"> - A resident was observed to drink from the water fountain. - The water fountain was still dirty and unclear. - There was no sign up to warn the water fountain was out of order. <p>Interview on 11/07/17 at 4:24 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - He did not realize the water fountain was in the current condition. - He would ensure the fountains would be "out of order" right away and it would be thoroughly cleaned. - He would assure the water fountain would be kept clean. <p>Observation on 11/07/17 at 11:13 a.m. of the common bathroom bath tub revealed:</p> <ul style="list-style-type: none"> - The caulking around the top rim of the tub had dried out cracks and had pulled away from the tub in areas. - Some of the caulked areas had a black mildew like substance on it. - There was black substance around the bath tub faucet where it met the tub wall. - The bath tub closure mechanism had some corrosion, and a black rust colored substance all around it where it met the wall of the tub. 	C 078		

Division of Health Service Regulation

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C 078	Continued From page 6 <ul style="list-style-type: none"> - There were rust colored streaks down toward the drain from the tub closure mechanism. - The drain had black stains on it. - There was a light blue colored stain on the bath tub wall and down toward the drain. - The bath tub walls and bottom of the bath tub were covered with a gray substance with a dirty appearance all around the tub and on the floor of the bath tub. - There was a thicker build-up of dirty areas at the head of the tub that were a brownish/gray color. - There were hairs and dirt particles throughout the bath tub walls and floor bottom. - The bath tub curtains were covered with a whitish soap scum substance and a brown/black build up along the bottom edge approximately 6-8 inches in width and the white soap scum was toward the middle of the curtain. <p>Interview on 11/07/17 at 4:38 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - There was a cleaning schedule. - Staff had different duties to complete. - Staff were to clean the bath tubs and showers every night. - The cleaning schedule had been modified since he had not been monitoring the cleaning of the facility. - He would ensure the bath tub and showers were cleaned when dirty and when residents were finished their baths. - He would increase the monitoring of the housekeeping. 	C 078			
C 205	10A NCAC 13G .0702(c)(2) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination	C 205			

Division of Health Service Regulation

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C 205	<p>Continued From page 7</p> <p>(c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:</p> <p>(2) The FL-2 or MR-2 shall be in the facility before admission or accompany the resident upon admission and be reviewed by the administrator or supervisor-in-charge before admission except for emergency admissions.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure 1 of 3 residents sampled had an FL-2 completed and received in the facility before or upon admission which resulted in the resident being the admitted without a level of care and no documentation of current orders. (Resident #1).</p> <p>The findings are:</p> <p>Interview on 11/7/17 at 10:04 a.m., with the personal care aide working in the facility revealed:</p> <ul style="list-style-type: none"> - Resident #1 had been moved to this facility from the Administrator's other facility about 1-2 weeks ago. - He was not aware there was not a current FL-2 for Resident #1 - "They just brought his books from the other facility." - He knew what to do for the resident by the FL-2 in his record.. - All of the MARs came over from the other facility and his medications. - The administrator and the assistant to the administrator get the FL-2's and the medication administration records (MARs) completed. 	C 205		

Division of Health Service Regulation

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C 205	<p>Continued From page 8</p> <p>Review of the resident record for Resident #1 revealed:</p> <ul style="list-style-type: none"> - There was not a current FL-2 for the admission to the facility. - There was no documentation of a current Resident Register. - There was no documentation of the date of admission to the facility. <p>Review of the previous facility's FL-2 dated 6/15/17 for Resident #1 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of traumatic brain injury, apparent mental retardation, and seizure disorder. - A level of care was listed as family care home. <p>Observation of Resident #1 on 11/7/17 at 10:47 a.m. revealed the resident was independently ambulatory and was smoking a cigarette.</p> <p>Interview on 11/7/17 at 10:47 p.m. with Resident #1 revealed:</p> <ul style="list-style-type: none"> - He had moved from the Administrator's facility next door to this one about 1 week ago. - He had lived in the other facility for a while and moved over to this facility for a change. - He continued to get his previous medications here. - He got a regular diet and snacks during the day. - There no problems of concerns regarding his care in the facility. <p>Interview on 11/7/17 at 1:18 p.m. with the Supervisor-In-Charge revealed:</p> <ul style="list-style-type: none"> - Resident #1 was at the Administrator's facility next door. - He was recently moved to this facility. - He was independent. - His medications and records were brought over to this facility when he moved in. - She did not know the exact day of the move to 	C 205		

Division of Health Service Regulation

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C 205	<p>Continued From page 9</p> <p>this facility.</p> <ul style="list-style-type: none"> - Recently he had his teeth removed and was getting dentures this week. - He was a smoker and staff would light the cigarettes outside the facility for him. - The Administrator completed all of the admission paperwork. <p>Interview on 11/7/17 at 1:20 p.m. with the assistant to the Administrator revealed:</p> <ul style="list-style-type: none"> - No FL-2 for Resident #1 had been completed since he came to the facility about a week ago. - She was not aware of why there was not a current FL-2 for the resident. - All of the residents medications and MARs were brought over from the other facility. - He was receiving dental care but he was mostly independent. - The facility cut up his meat because he had no teeth. He was waiting on dentures next week. - The Administrator was responsible for ensuring current FL-2's were obtained on admission. <p>Interview on 11/7/17 at 4:35 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - Resident #1 had been in the facility at most for 2 days. - All of his paperwork had been brought over to this facility when he was admitted. - He was independent and his previous care level was continued included the medications received at the other facility. - Nothing had changed with his care except he was recently fitted for dentures and was receiving dental care. - The Administrator said he "Just did not get the FL-2 and Resident Register completed for his admission here. - He would ensure the admission paper work would be completed. 	C 205		

Division of Health Service Regulation

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C 230	<p>10A NCAC 13G .0801(a) Resident Assessment</p> <p>10A NCAC 13G .0801 Resident Assessment (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure 1 of 3 residents sampled had a initial Resident Register assessment completed within 72 hours of admission to the facility which resulted in the resident not having an initial functional level of care assessment completed. (Resident #1).</p> <p>The findings are:</p> <p>Interview on 11/7/17 at 10:04 a.m. with the personal care aide working in the facility on the day shift revealed:</p> <ul style="list-style-type: none"> - Resident #1 had been moved to this facility from the Administrator's other facility about 2 1/2 weeks ago. - He was not aware there was not Resident Register initial assessment completed for Resident #1. - "They just brought his books from the other facility." - He knew what to do for the resident by the FL-2 in his record. - The resident was independent, had a mental illness and was a smoker. - All of the MARs and his medications came over from the other facility. - The Administrator and the assistant to the Administrator get the FL-2's and the medication administration records (MARs) completed. 	C 230		

Division of Health Service Regulation

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C 230	<p>Continued From page 11</p> <p>Review of the resident record for Resident #1 revealed:</p> <ul style="list-style-type: none"> - There was no documentation of a current Resident Register initial assessment within 72 hours. - There was no documentation of the date of admission to the facility. - There was not a current FL-2 for the admission to the facility. <p>Review of the previous facility's FL-2 dated 6/15/17 for Resident #1 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of traumatic brain injury, apparent mental retardation, and seizure disorder. - A level of care was listed as family care home. <p>Observation of Resident #1 on 11/7/17 at 10:47 a.m. revealed the resident was independently ambulatory and was smoking a cigarette.</p> <p>Interview on 11/7/17 at 10:47 p.m. with Resident #1 revealed:</p> <ul style="list-style-type: none"> - He had moved from the Administrator's facility next door to this one about 1 week ago. - He had lived in the other facility for a while and moved over to this facility for a change. - He continued to get his previous medications here. - He got a regular diet and snacks during the day. - There no problems of concerns regarding his care in the facility. <p>Interview on 11/7/17 at 1:18 p.m. with the Supervisor-In-Charge revealed:</p> <ul style="list-style-type: none"> - Resident #1 was at the Administrator's facility next door. - He was recently moved to this facility. - He was independent. - His medications and records were brought over to this facility when he moved in. 	C 230		

Division of Health Service Regulation

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C 230	<p>Continued From page 12</p> <ul style="list-style-type: none"> - She did not know the exact day of the move to this facility. - Recently he had his teeth removed and was getting dentures this week. - He was a smoker and staff would light the cigarettes outside the facility for him. - The Administrator completed all of the admission paperwork. <p>Interview on 11/7/17 at 1:20 p.m. with the assistant to the Administrator revealed:</p> <ul style="list-style-type: none"> - No FL-2 or Resident Register initial assessment for Resident #1 had been completed since he came to the facility about a week ago. - She was not aware of why there was not current paperwork for the resident. - All of the resident's medications and Medication Administration Records were brought over from the "sister facility". - He was receiving dental care but he was mostly independent. - The facility cut up his meat because he had no teeth. He was waiting on dentures next week. - The Administrator was responsible for ensuring current FL-2's and Resident Registers were completed. <p>Interview on 11/7/17 at 4:35 p.m. with the Administrator revealed:</p> <ul style="list-style-type: none"> - Resident #1 had been in the facility at most for 2 days. - All of his paperwork had been brought over to this facility when he was admitted. - He was independent and his previous care level was continued included the medications received at the other facility. - Nothing had changed with his care except he was recently fitted for dentures and was receiving dental care. - The Administrator said he "Just did not get the 	C 230		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/07/2017
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C 230	Continued From page 13 FL-2 and Resident Register completed for his admission here. - He would ensure the admission paper work would be completed.	C 230			