ID PLAN (TOF DEFICIENCIES OF CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING:		
				· ————————	COMPLETED	
LUC OF B		HAL081051	B. WING		09/20/2017	
	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
ANAS AS	SSISTED LIVING FACILI	FY ≠ 2 2270 OA	KLAND ROAD			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	CITY, NC 280			
TAG	(EACH DEFICIENC) REGULATORY OR E	Y MUSY BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D.BE COMO	
D 000	Initial Comments		D 000			
	County Department of	sure Section and Rutherford f Social Services conducted up survey on September				
D 074	10A NCAC 13F .0306 Furnishings	(a)(1) Housekeeping And	D 074		٠	
	reviews, the facility fail and floors or floor cove in good repair for 8 res #11, #13, #14, #15, #1 Hallway #3, a common Hallway #1 and the kito	shall: s, and floors or floor and in good repair, s evidenced by: s, interviews, and record ed to assure walls, ceilings, erings were kept clean and ident rooms (Room #6, #7, 6, and #21), the ceiling of shower/tub bathroom on		Manager/Stc Wi Monitor this on daily basic to en rule area is met All rooms (reside have been pounts Stripped & also and ceiling have pounted also.	a sure 1/31/ nt) ed f waxed been	
1	evealed:	#21 on 9/20/17 at 9:19am surrounding the top of the and coming loose		Bathroom Door h been repaired.	nas 1/3/1 ¹	
- f	The ceiling had multip: A wooden door to a sh illed with masking tape	le areas of brown stains. lared bathroom had a hole c.		All rooms have b repaired, painted &s	Stripped 110	
	Observation of Room # revealed;	7 on 9/20/17 at 9:28am		work ceiling pount	sed \bot	
of Heaith	h Service Regulation	PPLIER REPRESENTATIVE'S SIGNATURE		TI-TITLE AA 1.	011 1987	
FORM				a twhe Manager	Cel 11/6/2	
2011	1011Mal Man	d accepted with		Sims Jendu 12/1	If continuation shalet 1	

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION: IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL081051 B. WNG 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NG 28043 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 074 Continued From page 1 D 074 -The wall paper border surrounding the top of the room wall was peeling and coming loose. -The ceiling had multiple areas of brown stains. -There were two wall lamps; one with no bulb or shade cover lying on the ground, and one en done detached from the base and hanging/unsecured from base with bulb turned on. Observation of Room #16 on 9/20/17 at 9:19am revealed: -The wall paper border surrounding the top of the room wall was peeling and coming loose. -A closet with resident personal possessions with a large amount of rodent droppings on the floor. Observation of Room #14 on 9/20/17 at 9:32am -The paint on right wall of the room had multiple areas that were damaged and had exposed dry wall material present. -A closet with resident personal possessions with a large amount of rodent droppings, dust and debris on the floor. Observation of Room #15 on 9/20/17 at 9:34am revealed a closet with resident personal possessions, with a large amount of rodent droppings, dust and debris on the floor, discarded wall molding, and a discarded curtain hanger. Observation of Room #13 on 9/20/17 at 9:35am closet and clean revealed: -The wall paper border surrounding the top of the times aweek. room wall was peeling and coming loose. -An air conditioning vent hanging from the ceiling that was secured by only one screw. -A closet with resident personal possessions with 1 monitor on a a large amount of rodent droppings on the floor. -A plastic storage bin, in the closet, with resident personal possessions, had rodent droppings on Division of Health Service Regulation

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING: COMPLETED HAL081051 B. WNG 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NAMAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) 1D SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX (X5) COMPLETE TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY D 074 Continued From page 2 D 074 Manager & SIC Will Monitor on daily basics to make top of the storage bin. Observation of Room #6 on 9/20/17 at 10:25am revealed a closet with resident personal possessions, with a large amount of rodent droppings, dust and debris on the floor. Sure rule rule onea Observation of Room #11 on 9/20/17 at 9:39am revealed a large amount of rodent droppings on the floor of the closet. 12/10/17 Observation of the ceiling at the end of Hallway Ceiling has been repaired to met rule area #3 on 9/20/17 at 10:05am revealed: -A 4 by 4 ft. section of ceiling, on the right side of the hall, that was damaged by water. -The plaster was covered in a brownish-black substance in a one foot diameter circular area. -There was a 4-inch diameter area, in the center of the circular area, that was filled with yellow foam sealant. -Multiple areas of brown stains surrounded the water damaged area. Leiling has been repaired to met rule onea. and tiles also repaired. Observation of the common shower/tub/bathroom 12/10/17 on Hallway #1 adjacent to Room #9 on 9/19/17 at 12:00pm revealed: -The ceiling of the shower stall had a 6 x 6 ft. section of ceiling that had been partially repaired. -There was exposed original ceiling material that was covered with a black, mold-like substance around the edges of the 6 x 6 ft. area. -The ceramic tiles of the shower floor were dirty, stained and had debris. -Shower wall paneling with moderate water damage, coming from the wall above and surrounding where the showerhead comes out of the shower wall. Interview with a Medication Aide on 9/20/17 at 10:40am revealed: Division of Health Service Regulation STATE FORM

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PRINTED: 10/20/2017

AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(YS) DA	E SURVEY
	3	IDENTIFICATION NUMBER!	A. BUILDING:		COL	APLETED
	d.					
		HAL081051	B. WNG		,	R 9/20/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E. ZIP CODE		3/20/2017
NANAS A	SSISTED LIVING FACIL		AKLAND ROAD	,		
		FORES	T CITY, NC 28043			
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID .	SPOMER'S DIAMOS	0000000000	
TAG	REGULATORY OF	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT)	ION SHOULD BE	(X5) COMPLE
		- Company	TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE
D 074	Continued From page	20.2		DEFICIENC	·*)	
	1		D 074			
	-Residents used the	common				
	snower/tub/bathroon	n adjacent to Room #9.	1			
	-ine common tub/ba	athroom adjacent to room #7				
	was for staff only.					i
l	Observation of the ki	tchen on 9/19/17 and				İ
	9/20/17 revealed the	re were 12 floor tiles missing				
	in the food preparation	on area that revealed				ĺ
	exposed rough concr	rete flooring underneath.	-			
						2.0
ĺ.	sitting on a sofa in the	at 10:45am with a resident		*		ŀ
	revealed:	a living by the plano				
j	-"A mouse lives unde	r or in the piano and will run				Ì
F	over your feet if you're	e sittina here."				
!	-"He runs across the:	floor from one side of the				1
4	living room to the other	er."				
	 Sometimes if I'm rease him." 	ading, I'll hear him before I				
5	-"He can move pretty	fact "				
1.	-"The staff know we h	ave mice. They have seen				
1	them."	ave mice. They have seen				
	Interview on 9/19/17 a	it 3:30pm with a resident				
1	sitting in the living room	m in his wheelchair				1
		hot threat in the second				
	clothes in the bottom of	hat lived in a pile of his				
-	The mouse had lived	there for only a short time.	1			
-	He had named the mo	ouse [Name] after a staff				}
	erson who took good	care of him				le.
- -	It didn't bother him to	have the mouse living in				
hi	nis closet.	•				
]	nterview on 9/20/17 at	7:45am				
ا ا	erson revealed:	CHOAN WITH A STAFF		vi		
		in the facility for several			}	
l n	ionths. She had seen	them.				
-1	When it was really, rea	ally quiet she could hear				
l th	nem running across th	A floor	1		İ	

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If continuation sheet 4 of 25

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED HAL081051 R B. WING NAME OF PROVIDER OR SUPPLIER 09/20/2017 STREET ADDRESS, CITY, STATE, ZE CODE NAMAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 074 Continued From page 4 D 074 -The other staff knew there were mice because "we've all seen them". - The residents keep food in their rooms and that's probably why we have the mice." Interview with the Kitchen Manager on 9/20/17 at 9:22am revealed: -She had worked in the kitchen for 2 months. -The tile floors had been in this condition since she started working in the kitchen. -The facility was "getting ready to repair the floors." -She swept and mopped the kitchen area daily. Interview with the Maintenance/Housekeeping Director on 9/20/17 at 12:20pm and 3:15pm revealed: -He had worked in the facility for 3 to 4 years. -He was unaware that several rooms had issues with the wall papered border falling or paint damage exposing dry wall. -He was unaware that one room had an air vent hanging loose from the ceiling or one room with damaged wall lamps. -He was unaware of the water stains in several rooms and would paint over them. -He was unaware that the ceiling in Hallway #3 was an issue and stated "it has always been like -He had started to repair the shower wall and ceiling of the common shower/tub/bathroom on Hallway #1 "about 3 to 4 weeks ago", but had another issue come up that needed his attention. He had made attempts to clean rodent droppings on a "regular basis", but was unaware that rodent droppings were currently in the closets of several resident rooms. -The facility had placed sticky traps out for the mice in the past. -He and the housekeeping staff had checked the Division of Health Service Regulation STATE FORM

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If continuation sheet 5 of 25

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION		
		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DAT COM	E SURVEY PLETED
*		HAL081051	•			R
NAME OF P	ROVIDER OR SUPPLIER	TIALUGIUST	B. WNG		os	/20/2017
		STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
VANAS A	SSISTED LIVING FACIL	TY # 2 2270 O/	AKLAND ROAD			
(X4) ID	SUMMARY S	TATEMENT OF DECICIONAL	T CITY, NC 28043	·		
PREFIX TAG	(CACH DEFICIENC	Y MIST BE ODCCCOORDED AND THE	PREFIX	PROVIDER'S PLAN OF COM	RECTION	(X5)
	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOUD DE	COMPL
D 074	Ca-6			DEFICIENCY)	PROPRIATE	DATE
00,4	Continued From page	e 5	D 074			
	resident rooms and o	losets weekly, and had				
ļ	cleaned out the resid	ent's belongings to groups				
	mere were no rodent	droppings				
}	-He thought all the mi	ice were caught, and had				
1	me maps removed.					
	-Residents would take	e food to their rooms from	1 1			
1	THE KITCHEN.					
	-He had contacted pe	st control on 9/19/17 and	1			1
1	usey were onsite today	y to put down rodent traps	-			i
į	and bait.					
	Interview with Adminis	tmtor on 04047				
	11:00am revealed:	mater off 9/19/17 at				
		oors throughout the facility	1			
1 1	recuso to be repaired		}			
-	They had started world	K on the floors in the				
[6	willion areas.					
1-	They had been cleani	ng out the closets in the	1			
r	esident rooms.				ļ	
[ti	nterview with Administ	rator on 9/20/17 at 4:10pm				
111	evealed:					
-	She started working at	t the facility on 8/31/17.			1	
-	one was unaware of the	1e water stains in moidant				
15	roms, the ceiling of Ha	allway #3, and naint			ļ	
10	dinageo in resident ro	Λme.				
-5	one was aware of issu	es with the housekeeping				
1 31	an and would begin a	"deen rieen schodule"			ſ	
LE	iat the Administrator w	rould monitor for 1 month				
[0	in the Maintenance/H	OUSekeeping Director			1	
W	ould monitor the next,	and rotate monthly.				
R	eview of the Food Fet	ablishment Inspection	·		[
R	eport completed on 5/	31/17 revealed:			į.	
-A	score of 90,5	8] .			
-"	tem #53: Repairing Pr	emises Structures				
1 77.	lacilinents and Fixture	S-Methode: Continue to	1			
wo	ork to repair the walls	and floors, they must be				
sm	nooth, easily cleanable	and in good repair "			1	
	,		1			

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING:_ COMPLETED HAL081051 B. WNG 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY D 074 Continued From page 6 D 074 Review of the Facility Inspection Report completed on 6/6/17 revealed: -A score of 90. -"Item #3: Repair and repaint walls as needed throughout the facility, especially on the women's hall. The ceiling in the shower is damaged in the hallway restroom on the women's hall. There was a board put over the damaged area on the wall but it was not properly repaired, just covered." -"Item #24: There were rodent droppings observed in room 10 and 12." D 079 10A NCAC 13F .0306(a)(5) Housekeeping and D 079 **Furnishings** 10A NCAC 13F .0306 Housekeeping and Rest Home has sign 9/151
Contract with Bug
Contract with Bug
Control. The will spray
on a monthly basis
Staff Will take shot phill
Vaccin Language and **Fumishings** (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 and interviews the facility failed to assure the building was maintained in an uncluttered, clean and orderly manner, free of all Vaccum to closet and hazards, which resulted in a rodent infestation as evidenced by rodent droppings throughout the Clean 3 times a week. SIC will monitor on a facility, including the kitchen food preparation area, 4 resident rooms, and 3 vacant resident rooms. Division of Health Service Regulation

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY
·		HAL081051	B. WNG		· ·	R
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE ZIP CODE	09/	20/2017
NANAS A	SSISTED LIVING FACILIT		KLAND ROAD	" " "		
		FORES	T CITY, NC 2804	43		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID.	PROVIDER'S PLAN OF	CORRECTION		
TAG	REGULATORY OR 1	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPI COMPI
D 079	Continued From page	7	D 079	101 1000	1	
	The findings are:			daily basic	s to	
	Interview with a rocide	nt on 9/19/17 at 11:10am		encine mile	Mag is	
	revealed the resident i	nad seen a rodent in the		9 500 € 1000	01	
1	common living room th	nat moming running along		1 Met.		į
	the wall and behind a	couch near the TV.		• -		
ĺ	Observation of the kito	hen area on 9/19/17 at				
	12:15pm and 9/20/17 a	at 8:07am revealed:	-			
1	-There were rodent dro	oppings in cardboard	j	1		
	containers where cann	ed sliced carrots and				
	the dry storage area.	d on the metal shelving in				
	There was a woodon i	hree tier shelving unit in				
	the basement walk-in o	ooler/freezer area with	1 :		1	
	moderate amounts of n	odent droppings on the			}	
1	cookware and on all sh	elf surfaces	1 1			
1.	-The same shelving un	t was used to store metal				
- 1	baking pans, glass coo.	kware lids, plastic cake			•	
- 1	plates with lids, metal c	olanders, plastic serving				
1	trays and metal cake pa	ens.				
[]	- Iwo shelves adjacent 1	to the 3 compartment sink				
1	in the food preparation.	area of the kitchen had				
	rodent droppings on eac The same shelves wer	ch shelf.	1			
s	stoppers, detergent, and	e used to store sink d bleach for the kitchen.				
0	Observation of 4 resider	nt rooms on 9/20/17 from				
9	9:19am to 9:35am revea	aled:			ſ	
-	The closets in Rooms #	14, #15 and #16, with				
l n	esident personal posse	ssions stored within had				
16	arge amounts of rodent	droppings in the floor	.			
-	-A closet in Room #13 y	vith resident personal				140
Į P	odest department	in, had large amounts of				
1	odent droppings in the f	foor and on top of a				
1 4	lastic storage container	• r 1	1 [
o	Observation of 3 vacant	resident rooms on				
9,	/20/17 from 9:39am to 9	2:47am revealed the	1		į	
Cl	losets in Rooms #9, #1	D. and #11 had lame				
-F11-11	Service Regulation	-, n ri riad laige		al and a second		

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL081051 B. WNG 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) IO SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 079 Continued From page 8 D 079 amounts of rodent droppings on the floor. Review of the Food Establishment Inspection Report completed on 5/31/17 revealed: -A score of 90.5. -item #36 Controlling Pests: There were rodent droppings throughout the kitchen, especially in the cabinet on the counter, in front of the window, on the floor in front of the window, and in the basement walk-in cooler room. Must continue to work with pest control to eliminate the rodents and prevent their entry -Item #47 Non-food Contact Surfaces: Need to clean the cabinets and counters, there were rodent droppings present at the time of the inspection. -Item #53 Repairing Premises, Structures, Attachments and Fixtures-Methods: Clean the floors to remove rodent droppings. Review of the Facility Inspection Report completed on 6/6/17 revealed: -A score of 90. -"Item #24: There were rodent droppings observed in room 10 and 12. Must work with a licensed pest control company to control mice in the facility and kitchen." Interview on 9/19/17 at 10:45am with a resident sitting on a sofa in the living by the piano revealed: -"A mouse lives under or in the plane and will run over your feet if you're sitting here." -"He runs across the floor from one side of the living room to the other." -"Sometimes if I'm reading, I'll hear him before I see him." -"He can move pretty fast." -"The staff know we have mice. They have seen them." Division of Health Service Regulation STATE FORM

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PRINTED: 10/20/2017

Division	of Health Service Regu	ılation		5 ⁽⁴⁾		RM APPROVED
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(2)			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION		TE SURVEY
			A. BUILDING:		CO	MPLETED
	l,	1111 00000			ł	R
		HAL081051	B. WING		ه ا	9/20/2017
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	ZIP CODE		
NANASA	SSISTED LIVING FACILI		KLAND ROAD	421 0002		
	SOISTED ENTING PACIE		CITY, NC 28043			
(X4) ID	SUMMARY ST	ATEMENT OF DESIGNOISE	ID	700		
PREFIX TAG	LEACH DEFICIENC	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION:	RECTION	(X5)
	THE COUNTY OF L	SO IDENTIFTING INFORMATION)	TAG	CROSS-REFERENCED TO THE A	PPROPRIATE	COMPLETE DATE
				DEFICIENCY)		
D 079	Continued From page	: 9	D 079			
	Interview with Adminis	strator on 9/19/17 at				
	11:00am revealed the	y had been cleaning out the	1			
	closets in the resident	rooms				·
						1
	Interview on 9/19/17 a	t 3:30pm with a resident				
	sitting in the living root	m in his wheelchair	l i			
	revealed:					
	-There was a mouse to	hat lived in a pile of his				1
	clothes in the bottom of	of his closet				
	-The mouse had lived	there for only a short time.				1
	person who took good	ouse [Name] after a staff				1 1
	-it didn't hother him to	care of him. have the mouse living in	1 1			1
	his closet.	have the mouse living in				1
1	Interview on 9/20/17 at	7:45am with-a staff				
Į.	person revealed:					
Į.	-There had been mice	in the facility for several				
× [+]	months. She had seen	them.				
	-When it was really, rea	ally quiet she could hear				
- 1	them running across th	e floor.				1
	"we've all seen them".	nere were mice because	1			
	"The residents keep fo	and in their engage				. 1
ı	that's probably why we	bave the mice "				1
		The state times.				
1	nterview with the Kitch	en Manager on 9/20/17 at				
; \$	3:22am and 4:20pm rev	/ealed:				
•	She had worked in the	kitchen for 2 months.				
1 -	She was responsible to	or cleaning the kitchen and				
ءَ إ	iii storage areas.					1
]	one had not noticed the	e rodent droppings until				1
]	the was notified by the	surveyor,				
6	belving unit in the control	y storage area and the				
t t	oday.	-in coole /freezer room				
	There were currently no	o mouse tones in the				
k	itchen area.	о пючее нара п гле				
		going to purchase sticky	[
ision of Health	Service Regulation	a to purchase sticky		,		

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING: HAL081051 B. WING_ NAME OF PROVIDER OR SUPPLIER 09/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAMAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID PREF(X SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 079 Continued From page 10 D 079 traps for the area. -She swept and mopped the kitchen area daily. Interview with the Maintenance/Housekeeping Director on 9/20/17 at 12:20pm and 3:15pm revealed: -He had worked in the facility for 3 to 4 years. -He was unaware that rodent droppings were currently in the closets of several of resident rooms, a vacant resident room, and the kitchen food preparation area. -The facility had placed sticky traps out for the mice in the past. -He thought all the mice were caught, and had the traps removed. -Residents would take food to their rooms from the kitchen. -He was made aware of the rodent issue on 9/19/17 and had contacted pest control. -Pest control was in the facility on 9/20/17 to put down rodent traps. -He had made attempts to clean rodent droppings on a "regular basis". -He and the housekeeping staff had checked the residents rooms weekly and cleaned out the resident's belongings to assure there were no rodent droppings. Interview with the Administrator on 9/20/17 at 4:10pm revealed: -She was new to the facility and was not aware of the issues with rodent droppings in the resident closet floors or kitchen area. -She started working at the facility on 8/31/17. -She was aware of issues with the housekeeping staff and would begin a "deep clean schedule". -She and the Maintenance/Housekeeping Director will monitor the cleaning schedule on a rotating monthly basis. Division of Health Service Regulation

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: __ COMPLETED HAL081051 B. WING_ 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) D 079 Continued From page 11 D 079 The facility's failure to assure the building was maintained in an uncluttered, clean and orderly manner, free of all hazards, which resulted in a rodent infestation as evidenced by rodent dropping throughout the facility, including the kitchen food preparation area, 4 resident rooms, and 3 vacant resident rooms. This failure placed all residents at risk of contracting rodent borne illness and/or disease, and was detrimental to the safety, health and welfare of these residents, and therefore constitutes a Type B Violation. A Plan of Protection was provided by the facility on 9/20/17 and included the following: -The facility's exterminator was contacted and was in the facility at 3pm on 9/20/17. -The exterminator treated the common areas, kitchen, resident rooms, and closets, and put out bait in all areas. -Staff will obtain a dry vacuum to clean closets, rooms, and kitchen areas daily on 1st and 2nd shift. -The Administrator with maintenance and housekeeping will inspect common areas, resident rooms, closets, and kitchen area for signs of mice. -Each will swap off halls to check behind each other and document findings. -Exterminator will continue on monthly visits. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 4, 2017. D 105 10A NCAC 13F .0311(a) Other Requirements D 105 10A NCAC 13F .0311 Other Requirements Division of Health Service Regulation STATE FORM

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O MOCINE	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1140:			M APPRO
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY
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		HAL081051	B. WING		,	R
VAME OF P	ROVIDER OR SUPPLIER		5. 771143			20/2017
		STREET	LODRESS, CITY, ST	TATE, ZIP CODE		
IANAS A	SSISTED LIVING FACI	LITY # 2 2270 OA	KLAND ROAD			
0.00		FOREST	CITY, NC 2804	3		
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	İD	PROVIDER'S PLAN OF COR	DECTION	
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			ing	CROSS-REFERENCED TO THE A	PPROPRIATE	DATE
D 105	Continued From pag	ne 12	Ditos	32.10(21)		
			D 105	1		ļ
1	(a) The building and	all fire safety, electrical,	1	}		
1	care home should	mbing equipment in an adult			j	
	operating condition.	maintained in a safe and				
Ì	-Farening condition.				أسمده	
			1		:Khes	line.
!	This Rule is not met	as evidenced by-	l	,	VN NOI.	III_{iJ}
	TYPE B VIOLATION			//	M.	1
- 1	5 . =			All Fire Extinated or checked up or manager is marager is basics rule sure is me	9	
Í	Based on observation	ns, interviews, and record	1	(-v0)	\sim 1	
	reviews, the facility fa	iled to assure fire safety	1 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1' and	
	equipment was maint	tained in a safe and		MII, De	L Division	,
	equipment was maintained in a safe an operating condition related to 7 of 7 fire extinguishers.	elated to 7 of 7 fire	1		U IN EN	
[$\sim \sim \sim 1.0$		
-	The findings are:	ting condition related to 7 of 7 fire uishers.		1,00	111: ~ OK	
	are.]	du Sacra	1/11	
13	Review of a Fire Inspe	ection Report dated 5/17/17	1 1	When in the	TC LUI	
1	evesied:			2014	A WILL	
-	It was a Fire Inspection	on Report which		I kon ' di	OUNITY.	
10	tocumented the initial	date of inspection as		To another the	ا ۱۸ ا	
5	Visit 1 and a date of re	einspection as 5/17/17.		WALL TOWN	ale	
-	ervice due".	ire Extinguishers, "Annual	1	, K	nu a	
		ervice Extinguishers".	1	pher in	avec	
- 1			1	W 71	W.	
F	eview of the facility fl	oor plan revealed the		Masico rule		
110	cation of / fire exting	uishers within the facility			g	
	he exunguisher #1 M	as located on the right wall		euie - me		
a	t the end of Hallway #	3, beside the door exiting		3, 5	1	
10	me outside.		Į Į	1 -		
-r	the end of a share	as located on the right wall				
h	side the door swift -	illway off Hallway #3 and			į	
-F	eside the door exiting	to the smoking area]	
of	Hallway #1, beside F	as located on the left wall	1		j	
-F	ire extinguisher #/ w	as located by the vending]		Ţ	
m	achines at the interse	as located by the vending ection of Hallway #1 and	-		1	
Ha	allway #2.	Subit Of Flatiway #1 and	1			
	ire extinguisher #5 wa		ſ			

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PRINTED: 10/20/2017 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED R HAL081051 B. WNG 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2270 OAKLAND ROAD NAMAS ASSISTED LIVING FACILITY # 2 FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 105 Continued From page 13 D 105 the end of Hallway #2. -Fire extinguisher #6 was located on the right wall at the end of Hallway #2, beside the door exiting to the outside -Fire extinguisher #7 was located in the basement laundry room. Observations of the fire extinguishers revealed: -Extinguisher #1, an ABC extinguisher (used for organic materials such as wood, fabric, and paper, flammable liquids such as paint, flammable gases and electrical fires) with a yellow NAFED (National Association of Fire Equipment Distributors) tag which indicated, by hole punches, it had last been serviced in July 2015 and was void one year from that date. -Extinguisher #2, an ABC extinguisher with a yellow NAFED tag which indicated, by hole punches, it had last been serviced in July 2015 and was void one year from that date. -Extinguisher #3, an ABC extinguisher, with no tag indicating when it had last been serviced. -Extinguisher #4, an ABC extinguisher, with a yellow NAFED tag which indicated, by hole punches, it had last been serviced in July 2015 and was void one year from that date. -Extinguisher #5, a wet/dry extinguisher (an ABC extinguisher and an F extinguisher used on oil or grease fires) with a yellow NAFED tag which indicated, by hole punches, it had last been serviced in July 2015 and was void one year from that date. On the back of the tag, the only monthly Inspection Record listed 10/22/16 and the initials PA.

yellow NAFED tag which indicated, by hole Division of Health Service Regulation

-Extinguisher #6, an ABC extinguisher with a yellow NAFED tag which indicated, by hole punches, it had last been serviced in July 2015

and was void one year from that date. -Extinguisher #7, an ABC extinguisher with a

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL081051 B. WING_ NAME OF PROVIDER OR SUPPLIER 09/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAMAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NG 28043 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 105 Continued From page 14 D 105 punches, it had last been serviced in July 2015 and was void one year from that date. Interview on 9/19/17 at 3:27pm with the Administrator revealed: -She had been an Administrator at another facility. -She had been at this facility since 8/30/17. -She was aware the fire inspectors do not check the extinguishers. -The fire extinguishers had not been checked since 2015. -She was not aware the fire extinguishers needed to be inspected monthly. -Facility staff were unaware that they were responsible to check them each month. -She would find out what company serviced the fire extinguishers and have them checked as soon as an appointment could be made. -She would put a system in place to assure the extinguishers were checked monthly. Review of the National Association of Fire Equipment Distributors (NAFED) guidelines for monthly fire extinguisher inspections revealed: -Confirm the fire extinguisher is visible, unobstructed and in its designated location. -Verify the locking pin is intact and the tamper seal is unbroken. -Examine the extinguisher for physical damage, corrosion, leakage or a plugged nozzle. -Confirm the pressure gauge or indicator is in the operable range or position, and lift the extinguisher to ensure it is full. -Make sure the operating instructions instructions on the name plate are legible and facing outward. -Check the last professional service date on the tag. (A licensed fire extinguisher maintenance contractor must have inspected the extinguisher within the past 12 months.) Division of Health Service Regulation STATE FORM

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	Т	
		IDENTIFICATION NUMBER:	A. BUILDING:			SURVEY PLETED
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	· · · · · · · · · · · · · · · · · · ·	HAL081051	B. MNG			R
NAME OF P	ROVIDER OR SUPPLIER				09	/20/2017
			ADDRESS, CITY, STAT	E, ZIP CODE		NO.
NANAS A	SSISTED LIVING FACIL	ITY # 2 2270 O	AKLAND ROAD			
(X4) ID	Cibarana	FORES	T CITY, NC 28043			
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION	ON CUALIFICATE	COMPLE
			ing	CROSS-REFERENCED TO THE DEFICIENCY	(EAPPROPRIATE	DATE
D 105	Continued From pag	e 15	D 405	- CI MICHO!	· · · · · · · · · · · · · · · · · · ·	
			D 105			
	-Initial and date the b	pack of the tag.				
	damaged as weed servi	ice tags and missing,				
ĺ	the ligaged of used ext	tinguishers immediately to				į .
}	contracts for the extin	guisher maintenance				ļ
	contractor for the faci	lity.				Ì
ļ	Interview on 9/20/17	-t 0 D0				
	Administrator reveale	at 9:00am with the				
ĵ	-She thought thou has	ia; do fina in a sur sur sur sur sur sur sur sur sur sur				ł
	2017.	d a fire inspection in May				
1	0-1020 St 50 0	and the first				
1	THE WAS CHADIC TO IC	cate the inspection report.				
"						
į	The facility's failure to	assure 7 of 7 fire				
1	extinguishers were ma	aintained in a safe and			j	
ļ.,	operating condition pla	aced the residents at risk of			į	
11	hooms innettioning and	Vor non-functioning fire				
1 :	safety equipment bein	g available in the event of a				
1.3	me emergency. This fa	Bilure was detrimental to	1			
f t	ine safety, health and	welfare of the residents	1			
é	and constitutes a Type	B Violation.			1	
-						
i.		,				
F	Plan of Protection wa	as provided by the facility				
6	on 10/19/1/ and includ	led the following:		Dr.		
-	The facility will begin a	weekly check sheet to			ļ	
"	nonitor the fire extingu	lishers.			1	
14	waintenance and/or h /eekly.	ousekeeping to complete			1	
					ļ	
	Monitoring will be date	d and initialed.				
4	ated with name or initi	ers will be inspected and				
_	Manager and Administ	rate monthly.				
a	nd address in OLIO	rator will check weekly dity Improvement) staff				
ım	eetings to assure con	muy improvement) staff				
-0	On October 04 2017 r	named) Fire Protection				
S	ervice came to the fee	ility and tested all fire				
ex	dinguishers ARC and	carbon dioxide type was			1	
up	dated and a cold feet	was performed and all	1			
SAZ	ere positive.	mentionned alignali	1			
1 447			,			

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STATEMEN	of Health Service Re				FOR	ED: 10/20/20 [.] RM APPROVI
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 5:	(X3) DATE	SURVEY
		HAL081051	B. WNG			R
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS. CITY, S		09	/20/2017
NANAS A	SSISTED LIVING FACIL	UTY#2 2270 O/	KLAND ROAD			
(X4) ID		FOREST	CITY, NC 280			
PREFIX TAG	(VERVITOR DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	מו	PROVIDER'S PLAN OF CORR	-CTON	
	ALGORATORY OF	RESC IDENTIFYING INFORMATION)	PREFIX TAG	(FACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OLUBBE	COMPLETE DATE
D 105	Continued From pag	je 16	D 105	Del locator)		ļ
	-A total of 4 of 5 fire with 1 in compliance	extinguishers were updated,				
	CORRECTION DATI VIOLATION SHALL I 4, 2017.	E FOR THIS TYPE B NOT EXCEED NOVEMBER				
D 317	10A NCAC 13F .090	5 (d) Activities Program	D 317	Manager 951 Will make su residents an	C	
	10A NCAC 13F .0905	Activities Program		will make Sol	re.	12/1/201
	(d) There shall be a r	ninimum of 14 hours of a		MIN MANGE ZO	, –	197
	variety of planned are	UD activities per wook that		rocidents an	0_	
, ,	roune activities that	promote socialization, roup accomplishment,		doing activition adaily to	12.00	
	realive expression, in	Creased knowledge and	,	doing activity	465	
1.7	earthing of new skills.	Homes that care		on adaily t	nsice.	
e	exempt from this requi	its with HIV disease are irement as long as the		on a a any	il in	=
1 15	actility can demonstrat	e planning for each		SHOE WILL WY	ite 11 1	
1 11	esidents involvement	in a variety of activities		Nat had	_	
, 4	arrang, garries, exerc	ivities are group singing, sise classes, seasonal	-	hook on with	1 0	
P	arties, discussion gro	UDS drama recident		no I was a	DIVE	
1 00	Duncil meetings, book oppreciation, review of	TEVIEWS music		HCTIVITA		
st	Delling bees.	current events and		Staff Will Wr book on what Activity was a that day.		
TI	his Rule is not met as	s evidenced by:			1	
re	view, the facility failed	interviews, and record				l
, ,	ribuls of planned are	Un activities were			ł	
Pi	uvided each week, thi	at promoted socialization				f
1 111	ysical interaction, gro	up accomplishment, reased knowledge and			j	- 1
100	ring of new skills for	the 17 residents				
CUI	rrently living in the fac	cility.			1	
Th	e findings are:				į	
of Health S	ervice Regulation				1	

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL081051 B. WING R NAME OF PROVIDER OR SUPPLIER 09/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 317 Continued From page 17 D 317 Interview with the Administrator on 9/19/17 at 10:30am revealed the facility census was 17. Review of the September 2017 Activity Calendar revealed: -There were 18 hours of activities scheduled for the week of 9/17/17 to 9/23/17. -Activities scheduled for 9/17/17: "Sunday Service" (2:00pm to 4:00pm). -Activities scheduled for 9/18/17: "Word Search" (9:00am to 10:00am) and "Pedicure Day" (6:00pm to 7:00pm). -Activities scheduled for 9/19/17: "Choice of Activity" (9:00am to 10:00am) and "Bible Study" (6:30pm.to 8:30pm). -Activities scheduled for 9/20/17: "Garden Time" (9:00am to 11:00am) and "Choice of Activity" (6:00pm to 7:00pm). -Activities scheduled for 9/21/17: "Color Favorite Picture" (10:00am to 12:00pm) and "Trip to [Fast food] and [Discount Store] (5:30pm to 7:30pm). -Activities scheduled for 9/22/17: "Nail Day (9:00am to 10:00am) and "Bingo" (2:00pm to 4:00pm). -Activities scheduled for 9/23/17:"Garden Club" (2:00pm to 4:00pm). Observations during the survey on 9/19/17 between 11:00am and 4:00pm revealed: -A Karaoke machine played from 10:30am to 12:00pm with several residents and staff singing -No other activity had taken place during that Observations during the survey on 9/20/17 between 7:00am to 4:00pm revealed: -Bingo was played in the Dining Room for approximately one hour. Division of Health Service Regulation STATE FORM DHCD11

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL081051 B. WING NAME OF PROVIDER OR SUPPLIER 09/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 317 Continued From page 18 D 317 -No residents had been seen gathering for, or participating in, "Garden Time". Confidential interviews on 9/19/17 with five residents revealed: - They have an activities calendar but we never do any of the activities." -"They normally don't do Karaoke. It's only because you're [the State] here." -"I keep busy watching TV in my room and walking the halls so I don't lose the use of my legs." -"I watch TV in my room and I smoke on the porch. That's all there is to do here." -"It is really boring here." -"We don't have no garden club and we sure don't have no garden." -"They have crossword puzzles and word searches listed as activities. Some of us can't even read, some us can't write, some folks eyes are so bad they can't see good, a couple can't hold a pencil and some can't sit still longer than two minutes because they need to go and smake." Interview with a staff member revealed: -All staff are responsible for telling the residents what activity is being done and asking them to participate. -"We sometimes play Bingo and do Karaoke with the residents." -"A lot of the residents just want to sit on the front porch and smoke." -"Other residents just want to lie on their beds and sleep." Interview with a second staff member revealed: -"Sometimes we do coloring with the residents." -"Sometimes we play Bingo, Karaoke and board games with them, too." Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING:_ COMPLETED HAL081051 R B. WING 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPPOPRIATE TAG DATE DEFICIENCY) D 317 Continued From page 19 D 317 -"We have cookouts in the summer for them." Interview with a third staff member revealed: -The residents like fast food. -"Sometimes the facility will buy a variety of fast food and have like a buffet." -"The residents are given play money to use and they can buy what they want to eat as long as they have the money." -"That way they get a change from the food they get every day." Interview with the Administrator on 9/19/17 at 2:55pm revealed: -The facility did not currently have an Activities Director. -The Resident Care Coordinator was the one who did the activities calendar. -The staff on duty were responsible for running the activities each day. -She was aware the activities were not offered as scheduled. -She was aware there was not 14 hours of activities scheduled each week. -She was aware the residents complained of being bored. -Even when activities the residents asked for were presented, they did not participate. -She had recently started making sure activities were done two hours daily. -There had been no documentation of an Activity Program in the past. -She was not aware of the facility having "fast food buffets" for the residents. -She would be discussing adding an Activity Director with the owners of the facility. Interview with Administrator on 9/20/17 at 4:10pm revealed she was aware that the activities were not being completed or offered 14 hours weekly. Division of Health Service Regulation

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED HAL081051 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NAMAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 319 10A NCAC 13F .0905 (f) Activities Program D 319 SIC! Manager Will make Sure residents pall 12/81 go on outing every 20th other month STG 10A NCAC 13F .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so. Marger Will Monitor this on a daily Basic to make Sure rule area is This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to assure that each resident had the opportunity to participate in at least one outing every other month. The findings are: Interview with the Administrator on 9/19/17 at 10:30am revealed the facility census was 17. Observation and review of the September 2017 activity calendar revealed there were no outings scheduled on the calendar. Observations of the parking area in front of the facility revealed: -Three dust covered vans parked side by side. -One van had a flat tire. -All three vans had expired tags. -These three vans were the vans observed to be non-operational by the surveyor during the survey completed on 10/27/16. -Another van was parked in the driveway at one end of the facility and had current tags. Interviews on 9/19/17 between 11:00am and Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION . (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED HAL081051 R 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETE TAG DATE DEFICIENCY) D 319 | Continued From page 21 D319 3:30pm and on 9/20/17 between 7:30am and 3,00pm with ten residents revealed; -Three residents stated the only time the staff took them anywhere was to doctor appointments. -Four residents stated they had never gone on an outing because there were no outings. -One resident said she would really like to go [to a local drive through] for a hamburger or to a local restaurant for fish "like we did a long time ago". -Two residents said they would like to go out in the van, "look at the leaves and stop for hot chocolate". -Several residents said they wished they could go shopping. Interview with a staff member revealed: -"The residents don't go on outings because the [facility] vans don't run." - When they have doctor's appointments, one of the staff takes them in her own car." Interview with a second staff member revealed the facility did not take residents on outings because the vans do not run. Interview on 9/19/17 at 2:55pm with the Administrator revealed: -The facility did not have an Activities Director. -The Resident Care Coordinator was the one who did the activities calendar. -The staff on duty were responsible for running the activities each day. -There had been no documentation of an Activity Program in the past. -She did not know if the facility vans were operational or currently being used. -She had been told by the Resident Care Coordinator the residents had been taken on outings. Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING:_ COMPLETED HAL081051 B. WING NAME OF PROVIDER OR SUPPLIER 09/20/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 319 Continued From page 22 D 319 Interview on 9/19/17 at 4:00pm with the Maintenance Director revealed: -The three vans were not working. -The battery in one van was "dead". -One van had a flat tire. -The other van needed 'work". -Transportation of residents to doctor's appointments was done by a staff member using their own vehicle. Interview with the Administrator on 9/20/17 at 1:05pm revealed: -The owner was responsible for transportation. -"I didn't realize [the] vans did not work." A second interview on 9/20/17 at 2:30pm with the Administrator revealed: -She had initially been told by the maintenance person the three facility vans were working. -When she had asked again, the Maintenance Director had told her one of the vans had a flat tire, a second van had "problems" but was fixed, and the third van, the battery had been "dead" but replaced and the van currently working. -All three vans had expired tags. -All three vans were without insurance. -"Several residents, earlier today, had been taken down the street to shop at a discount store in the maintenance person's car." -She will make sure at least one van is running, has current tags and insurance. -She will make sure the activity calendars include outings. Interview on 9/20/17 at 3:15pm with the Maintenance Director revealed: -There are four vans at the facility. -Of the four vans, "one is a personal van that is just parked at the facility". -The other three vans were operational but there Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED HAL081051 B. WING 09/20/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NANAS ASSISTED LIVING FACILITY # 2 2270 OAKLAND ROAD FOREST CITY, NC 28043 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG COMPLETE TAG CROSS-REFERENCED TO THE APPRIORRIATE DEFICIENCY) D 319 Continued From page 23 D 319 is "no insurance on them or valid license plates". -The facility has to use personal vehicles to take residents out of the facility. -Currently, [the facility] does not take residents on activities outside of the facility. Manager & SIC
Will make Sure
out resident rights
are met on a daily
basics by rule &
regulation D912 G.S. 131D-21(2) Declaration of Residents' Rights D912 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 which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings and fire safety equipment. The findings are: A. Based on observations and interviews the facility failed to assure the building was maintained in an uncluttered, clean and orderly manner, free of all hazards, which resulted in a rodent infestation as evidenced by rodent droppings throughout the facility, including the kitchen food preparation area, 4 resident rooms, and 3 vacant resident rooms. (Refer to Tag 0079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. Division of Health Service Regulation

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j			D912			
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: 	equipment was main	trained in a safe and				
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