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B & B ASSISTED LIVING # 7	2133 PRESTON ROAD MAXTON, NC 28364

(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
C 000	Initial Comments The Adult Care Licensure Section and the Roberson County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on February 27-28, 2018.	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 maintain walls, ceilings, and floors were kept clean and in good repair in 4 resident rooms, 2 bathrooms, 2 doorways, the hallway, and the dining and living rooms. The findings are: Observation of Resident Room #1 on 2/27/18 at 9:35 a.m. revealed: -There was a darkened area of paint on the wall above the nightstand approximately 2x3 feet wide. -There was a 2 foot long black scrape on the bottom of the closet door. Observation of the exterior door to the left of the hallway on 2/27/18 at 9:39 a.m. revealed: -There was an area of chipped wood at the base of the door frame approximately 6 inches long. -There was chipped white paint around the door	C 074		

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C 074	Continued From page 1 frame. -There were spots of rust on the top of the door frame. Observation of the hallway on 2/27/18 at 9:50 a.m. revealed: -There was a vent on the ceiling that was rusted. -The attic door was covered in brown smudges. Observation of the hall bathroom on 2/27/18 at 9:43 a.m. revealed: -There were two 4x4 foot areas of darkened paint on the wall to the left of the linen closet. -There was a long black scrape mark across the bottom of the linen closet door. -There was dried, brown liquid splatter on the wall to the right of the toilet. -There was a dried, yellow and brown substance on the wall to the right of the window. -There was chipped paint on the wall extending 1 foot above the baseboard to the left of the linen closet. -There was dust in the grates of the vent on the ceiling. -There was dust in the vents of the exhaust fan. Observation of Resident Room #3 on 2/27/18 at 9:52 a.m. revealed: -There were various dried, yellow and brown liquid stains on the wall to the left of the nightstand. -There were several small holes in the plaster on the wall to the right of the window. -There was a 2 foot long area of a dark stain on the wall behind the television. Interview with the resident on 2/27/18 at 9:49 a.m. revealed she was not sure how often staff cleaned the walls.	C 074		

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C 074	Continued From page 2 Observation of Resident Room #6 on 2/27/18 at 10:02 a.m. revealed: -There were multiple chips in the wood on the base of the door frame. -There was a black line approximately 2 inches above the baseboard around the corner of the wall to the right of the window. Observation of the handicap accessible bathroom on 2/27/18 at 10:05 a.m. revealed: -There was a 3 foot long black scrape on the right wall. -There was a 4 foot long water stain on the ceiling by the light fixture. -There were 2 lines of gray scrapes on the wall approximately 3 feet long. -There was a 1 foot long scrape on the wall under the cabinet. -There was rust on the ceiling vent above the walk in shower. -There were multiple black marks on the door frame extending upwards approximately 18 inches from the floor. Observation of the exterior door closest to the right of the hallway on 2/27/18 at 10:14 a.m. revealed there was a long plastic strip that had detached from the base of the door sill. Observation of the dining room on 2/27/18 at 10:21 a.m. revealed there was a 1 foot long scrape on the wall to the right of the entrance door. Observation of the living room on 2/28/18 at 8:11 a.m. revealed there were 2 foot long scrapes on the wall to the right of the front door. Interview with the Administrator on 2/28/18 at 12:15 p.m. revealed:	C 074		

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C 074	Continued From page 3 -The living room and dining room were painted in December 2017. -The scrapes on the walls were caused by the Geri chairs. -Most of the scrapes and scratches on the walls had been there prior to the change in ownership. -She had planned to have the bedrooms and bathrooms repainted but had not done so yet. -There was a maintenance director who completed repairs at the facility. -She would have the maintenance director clean the vents on the exhaust fans. -She would have the maintenance director replace the plastic stripping on the door sill.	C 074		
C 076	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (3) have furniture 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 maintain furniture in good repair to include 3 nightstands and 4 dressers in 4 of 5 resident rooms. The findings are: Observation of Resident Room #3 on 2/27/18 at 9:52 a.m. revealed: -There were multiple scratches on the top of both nightstands in the room. -The second drawer of the dresser was missing a handle on the right side.	C 076		

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C 076	Continued From page 4 Interview with a resident on 2/27/18 at 9:49 a.m. revealed the condition of the furniture in her room had been the same since she moved to the building approximately one year ago. Observation of Resident Room #6 on 2/27/18 at 10:02 a.m. revealed: -There was a white splatter on the bottom drawer of the dresser. -There were several scratches on top of the nightstand. Observation of Resident Room #2 on 2/27/18 at 10:04 a.m. revealed: -There were scratches on top of the dresser and on the three bottom dresser drawers. -There were various areas of white paint splatter on the left side of the wooden dresser. Observation of the Resident Room #1 on 2/27/18 at 10:10 a.m. revealed: -There was a scratch on the top left side of the dresser. - There were multiple scratches on the left side of the dresser on the middle and bottom drawers. Interview with the Administrator on 2/28/18 at 12:15 p.m. revealed: -She had been pricing new nightstands and dressers for the facility but had not yet replaced them. -She was responsible for ensuring the furniture was kept in good repair.	C 076		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL	C 453		

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C 453	Continued From page 5 RESTRAINTS AND ALTERNATIVES (a) A family 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,	C 453		

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C 453	Continued From page 6 providing activities, controlling pain, providing an 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 record reviews, observations and interviews, the facility failed to assure orders for physical restraints were obtained for 2 of 2 residents sampled (Resident #3 and #4). The findings are: 1. Review of Resident #3's current FL-2 dated 2/20/18 revealed: -Diagnoses included seizures, fibrocystic breast disease and mental retardation. -The resident was listed as constantly disoriented. -The resident was listed as ambulatory with assist. Observation of Resident #3 on 2/27/18 at 9:45am revealed: -The resident was sitting in a Geri chair by the front door with a tray table attached. -There were no items on the table tray. -The resident was watching television. -The Supervisor-in-Charge (SIC) was in the kitchen out of direct line of sight of the resident. Review of Standard Orders for Medication and Treatment form dated 2/22/18 revealed: -Order number 14 on the list of standing orders was worded: "Geri Chair or Hospital Beds - Used	C 453		

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as an enabler, not a restraint."
-The order was signed by the PCP of Resident #3.
-The form had Resident #3's name listed at the top.
-There was no mention of a tray table.

Based on observations, interview and record review, it was determined that Resident #3 was not interviewable.

Review of Resident #3's Care Plan dated 2/21/18 revealed:
-She required limited assistance with ambulation and was constantly disoriented.
-She required "ambulation assistance with aide or device," but no devices were noted.
-There was no notation for a Geri chair.

Review of Resident #3's record revealed no order, evaluation of restraint alternatives, or consent for use of Geri chair with a tray table as a restraint.

Interview with the SIC on 2/27/18 at 10:30am revealed:
-She lived in the facility full time.
-Resident #3 was unable to remove the tray from the Geri chair.
-Resident #3 had seizures and was unable to walk independently.
-Resident #3 would fall if the tray was removed and she was not around.
-She used the tray to ensure Resident #3 would not fall out of the chair.
-She checked on Resident #3 constantly, but did not remove the tray unless she was toileting the resident or preparing her for bed.
-She checked on Resident #3 at least every hour to determine toileting needs.

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-She felt confident that Resident #3 could not injure herself when she had to leave the room to go to the kitchen to prepare meals or perform cleaning duties at the facility.
-She considered the tray table a form of safety.
-The facility had a doctor's order for the Geri chair and tray which was listed as an enabler and not a restraint.

Interview with the guardian of Resident #3 on 2/28/18 at 11:30am revealed:
-Resident #3 could not walk on her own in the last year.
-Resident #3 would fall if the tray were removed.
-She considered the tray to be a safety precaution because Resident #3 fell out of her chair when she used to be at home years ago.
-Resident #3 was non-verbal and did not have the ability to remove the tray nor ask for the tray to be removed.
-The staff and PCP were aware that the tray was needed to prevent injury.
-She did not feel the tray was a restraint and the staff often removed Resident #3 from the chair when they were not busy performing duties at the facility.
-The staff sat by Resident #3's side when they were not performing cooking or cleaning duties and would remove the tray "throughout the day" when she visited.

Interview with the PCP for Resident #3 on 2/28/18 at 1:30pm revealed:
-She was the PCP of record for Resident #3.
-She was aware that the tray tables on the Geri chair was in use and approved of its use.
-She understood how the addition of the tray table and a resident's inability to remove the tray table would be considered a restraint.
-She would initiate the proper paperwork for an

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assessment and write the order for a restraint for Resident #3.
-She was happy with the care that Resident #3 received at the facility.
-Resident #3 was clean and well-groomed.
-The facility always notified her of any changes in physical and mental status related to Resident #3.
-Resident #3 was a fall risk but she would contact the Administrator immediately to ensure the trays were removed until she could provide the proper documentation which would include and order for a restraints and to request staff training on the use of restraints.

Observation of Resident #3 on 2/28/18 at 10:30am revealed:
-The resident was sitting in a Geri chair with the tray table attached.
-The resident was watching television.
-The Supervisor-in-Charge (SIC) was cleaning one of the resident rooms and not direct line of sight of the resident.

Refer to interview with Administrator on 2/28/18 at 12:23pm.

2. Review of Resident #4's current FL-2 dated 4/17/17 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, cardiovascular disease and history of right femur fracture.
-The resident was listed as constantly disoriented.
-The resident's ambulatory status was listed as "minimal ambulation."

Observation of Resident #4 on 2/27/18 at 9:45am revealed:
-The resident was sitting in a Geri chair in the

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living room across from the laundry room door with a tray table attached.
-There were no items on the table tray.
-The resident was watching television.
-The Supervisor-in-Charge (SIC) was in the kitchen out of direct line of sight of the resident.

Based on observations, interview and record review, it was determined that Resident #4 was not interviewable.

Review of Resident #4's Care Plan dated 4/12/17 revealed:
-She was ambulatory with the use of a rolling walker and was constantly disoriented.
-There was no notation for a Geri chair.

Review of Resident #4's record revealed no order, evaluation of restraint alternatives, or consent for use of Geri chair with a tray table as a restraint.

Interview with the SIC on 2/27/18 at 10:30am revealed:
-Resident #4 was unable to remove the tray from the Geri chair.
-Resident #4 could not walk on her own.
-Resident #4 would fall if the tray was removed and she was not around.
-She used the tray to ensure that Resident #4 would not fall out of the chair.
-She checked on Resident #4 constantly but did not remove the tray unless she was toileting the resident or preparing her for bed.
-She felt confident that Resident #4 could not injure herself when she had to leave the room to go to the kitchen to prepare meals or perform cleaning duties at the facility.
-She considered the tray table a form of safety.
-She checked on Resident #4 at least every hour

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to determine toileting needs.
-The facility had a doctor's order for the Geri chair and tray which was listed as an enabler and not a restraint.

Interview with the family member of Resident #4 on 2/27/18 at 11:32am revealed:
-She visited Resident #4 almost daily and found her clean and groomed each visit.
-Resident #4 could not walk on her own but would sometimes walk with assistance.
-Resident #4 would fall if the tray were removed and she liked knowing the tray was in use to prevent falls.
-She considered the tray to be a safety precaution because Resident #4 fell out of her chair in the past prior to arriving at the facility.
-Resident #4 was minimally verbal and did not have the ability to remove the tray nor ask for the tray to be removed.
-The staff and PCP were aware that the tray was needed to prevent injury.
-She did not feel the tray was a restraint and the staff often removed Resident #4 from the chair when they were not busy performing duties at the facility.
-She was uncertain how often the tray was removed but had visited on "several occasions" when the tray was removed and a staff member was always at Resident #4's side.

Interview with the PCP for Resident #4 on 2/28/18 at 1:30pm revealed:
-She was the PCP of record for Resident #4.
-She was aware that the tray tables on the Geri chair was in use and approved of its use.
-She understood how the addition of the tray table and a resident's inability to remove the tray table would be considered a restraint.
-She would initiate the proper paperwork for an

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assessment and write the order for a restraint for Resident #4.
-She was happy with the care that Resident #4 received at the facility.
-Resident #4 was clean and well-groomed.
-The facility always notified her of any changes in physical and mental status related to Resident #4.
-Resident #4 was a fall risk but she would contact the Administrator immediately to ensure the trays were removed until she could provide the proper documentation which would include and order for a restraints and to request staff training on the use of restraints.

Review of the Licensed Health Professional Support Clinical Skills evaluation for the Supervisor in Charge (SIC) dated 9/27/08 revealed use of restraints was not a validated skill.

Review of Standard Orders for Medication and Treatment form dated 2/22/18 revealed:
-Order number 14 on the list of standing orders was worded: "Geri Chair or Hospital Beds - Used as an enabler, not a restraint."
-The order was signed by the PCP of Resident #4.
-The form had Resident #4's name listed at the top.
-There was no mention of a tray table.

Observation of Resident #4 on 2/28/18 at 10:30am revealed:
-The resident was sitting in a Geri chair with the tray table attached.
-There was a multi-colored patchwork cloth with buttons on her tray.
-The resident was watching television.
-The Supervisor-in-Charge (SIC) was cleaning

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C 453	Continued From page 13 one of the resident rooms and not direct line of sight of the resident. Refer to interview with Administrator on 2/28/18 at 12:23pm. Interview with the Administrator on 2/28/18 at 12:23pm: -The facility had standing orders for the Geri chairs as "to be used as an enabler and not as a restraint." -Resident #3 and #4 did not have the ability to remove the trays by themselves. -She did not know that a resident's inability to remove the tray was considered a restraint. -The trays were "in place for safety reasons and to prevent falls." -The PCP was aware of the Geri chairs and trays being utilized at the facility. -She felt that the residents were safe when the SIC or other staff were out of direct line of sight because the trays were in place. -She did not know that an assessment for physical restraints had to be completed and alternatives to physical restraints had to have been tried prior to the application of physical restraints. -She did not know that the current standing order for the Geri chair to be used as an enabler was insufficient since the tray being attached made it a restraint. -She would contact the PCP and seek the proper assessment and documentation for the trays to be utilized. -She acknowledged that the trays could be perceived as a restraint. -She would immediately remove the trays and have direct staff one-on-one care for the two residents in the Geri chairs.	C 453		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078098	A. BUILDING: _____ B. WING _____	R 02/28/2018

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C 453	Continued From page 14 The facility's failure to ensure that Resident #3 and #4 could remove the tray tables from their Geri chairs. The residents who were listed as ambulatory with assist were restricted to freely ambulate about the facility when staff were not present in the same room. This was detrimental to the health and safety of the two residents. This constitutes a Type B Violation. _____ Review of the facility's Plan of Protection dated 2/28/18 revealed: -The trays would be immediately removed from the Geri chairs as of 2/28/18. -One-on-one supervision would be provided and all staff would be educated to only use the trays during activities and meals as of 2/28/18. -The PCP would be contacted for a restraint assessment and restraint order. -All staff would be trained on restraint usage and education by 3/1/18. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 14, 2018.	C 453		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 review, the facility failed ensure residents received care and services which are adequate,	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 912	Continued From page 15 appropriate and in compliance with relevant federal and state laws and rules and regulations as related to restraints. The findings are: Based on record reviews, observations and interviews, the facility failed to assure orders for physical restraints were obtained for 2 of 2 residents sampled (Resident #3 and #4). [Refer to Tag 0453 10A NCAC 13G .1301(a)(1) (Type B Violation)]	C 912		