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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 01/31/23 to 02/01/23.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure the facility was maintained in a clean and orderly manner and free of hazards including live and dead bed bugs, roaches, and mice throughout the facility. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 94 beds including 62 beds for assisted living (AL) and 32 beds for a special care unit (SCU). Review of the facility's census reports provided on 01/31/23 revealed: -The facility's in-house census was 60 residents.	D 079		

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D 079	Continued From page 1 -There were 35 residents residing in the AL side of the facility. -There were 25 residents residing in the SCU. Review of the facility's current sanitation report dated 06/20/22 revealed: -The facility's sanitation score was a 93. -The facility was to be free of vermin to include roaches, mice, and bed bugs. -There were mouse droppings observed on the SCU. -Resident items were not to be stored on the floor. Review of the facility's bed bug policy (no date) revealed: -Facility staff were to inspect all resident rooms monthly to include the mattress, box spring, bed frame, behind bed, dressers, closets, chair, linens, and clothing for bed bug activity and report any findings to the quality improvement director. -Rooms with bed bug activity were to be vacuumed daily. -Clothing and linens with bed bugs were to be dried in high heat, then washed and dried again. -Rooms were to be cleared of clutter and trash without items stacked in corners or along walls. -Rooms were to be cleaned daily and trash removed. Review of the resident bed bug policy agreement dated 08/18/16 revealed: -Any time a resident observed a bed bug they were to report the issue to the supervisor in charge. -Cardboard boxes, including shoe boxes were prohibited from being brought into the facility or used as storage. -All clothing and non-clothing items should be stored in plastic containers.	D 079		

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-All food items must be kept in a sealed airtight container.
-Staff were trained to detect bed bug sightings and would follow preventative protocol of vacuuming, bagging, and washing all linens and clothing, and cleaning mattresses and furniture.

Review of the facility's contracted exterminator's preparation letter for treatment dated 01/25/19 revealed:
-All clothing items must be off the floor and placed in plastic bags.
-All items must be out of dresser drawers and placed in plastic bags.
-All bedding must be removed, washed, dried, and placed in a plastic bag on the day of treatment.
-Residents must leave the room on the day of treatment and not return for 1-2 hours until chemical is dry.

Review of the facility's contracted monthly extermination receipts revealed:
-On 01/23/23, the facility was treated for bed bugs in resident rooms 1, 3, 7, 8, 12, 15, 37, 44, and 45.
-Box springs for rooms 47 and 44 were removed.
-All rooms were treated for general pests.
-Rodent bait stations were replaced.
-On 12/20/22, the facility was treated for general pests and bed bugs in resident rooms 1, 4, 8, 39, 42, 43, 44 and 45.

Observation of the occupied resident room #39 on the back hall of the AL side of the facility on 01/31/23 at 8:45am revealed:
-There were several live bed bugs crawling on the bedspread and walls.
-There were several live bed bugs and black residue in the zipper seams and inside a

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decorative pillow that was on the bed.
-There were 2 live bed bugs crawling on the shower curtain in the bathroom.

Interview with a resident that resided in room #39 on the back hall of the AL side of the facility on 01/31/23 at 8:45am revealed:
-She saw live bed bugs and roaches daily.
-She saw bedbugs in her bedroom and bathroom.
-Bed bugs were worse in resident room #45.
-She had shown the Administrator and the business office manager the live bugs. (No date was given)

A second interview with a resident that resided in room #39 on 01/31/23 at 11:00am revealed:
-She lived on the back hall of the assisted living (AL) unit.
-Bed bugs had gotten in her hair two to three weeks ago; she itched at the base of her skull and in her hair.
-She felt the bugs crawling in her hair worse at night and it woke her up at times.

Interview with a second resident in resident room #39 on 01/31/23 at 11:15am revealed he was awakened almost nightly by bugs crawling on him and biting him on his feet and lower legs.

Second observation of resident room #39 on 02/01/23 at 8:56am revealed there were boxes of food stored on the floor and windowsill, a bed bug crawled on the box spring and there were dead bed bugs on the ceiling.

Observation of the occupied resident in room #45 on 01/31/23 at 8:58am revealed there were red bumps over his arms and around the sides and back of his neck; many were scabbed over.

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Observation of the occupied resident room #45 on 01/31/23 at 8:58am revealed there were numerous live bed bugs of varying sizes on the mattress, box springs and sheets and blood spots and smears on his pillow and box spring.

Interview with the resident in room #45 on 01/31/23 at 8:58am revealed:
-He saw roaches in his room and bathroom often.
-He was bitten by bed bugs every night.
-He would feel bed bugs crawling on him at night and would wake up itching.
-He saw roaches in his room and bathroom often.
-He informed the business office manager and the Administrator of the bugs and bites.
-His bed sheets were changed 3 times a week and his bedroom was vacuumed daily.

Second interview with the resident in room #45 on 02/01/23 at 9:28am revealed his belongings had never been bagged up to prepare for extermination treatments.

Interview with a resident in room #35 on 02/01/23 at 8:32am revealed:
-She did not have bed bugs in her room, but she saw a lot of roaches and had seen mice in her room.
-She last saw a mouse in her room about a month ago.
-She saw roaches in her room almost daily.
-About a month ago a roach crawled across her stomach and woke her up.
-She found a roach crawling on her arm a couple of weeks ago.
-She had made the Administrator aware of the roaches and mice several times.
-The Administrator told her that someone was coming out to the facility to spray.
-An exterminator came and put some powder

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down in her room about a month ago, but it did not seem to help because she still had roaches in her room.

Observation of the occupied resident room #36 on 02/01/23 at 9:34am revealed:
-There were 2 bed bugs crawling on a resident's shirt while she was seated on her bed in room #36 and bed bugs at the seams of the mattress.
-There were 3 bed bugs crawling on the ceiling
-There was clothes and boxes in the corner and on the dresser of her room.

Interview with a resident in room #36 on 02/01/23 at 9:34am revealed:
-She saw 2 big and 2 little bed bugs by her bed and killed one on the air-conditioning unit the night before.
-She argued with the exterminator on his last visit because he said he didn't see any indication of activity and wouldn't treat her room.
-She had never been asked to pack or had her belongings packed up prior to extermination treatment.

Observation of resident bedroom #37 on the back hall of the AL unit on 01/31/23 at 10:50am revealed there were numerous red spots, scratches, and scabs on his upper and lower extremities.

Interview with the resident in room #37 on 01/31/23 at 10:50am revealed:
-He scratched his arms and legs because they were always itching.
-He had seen bed bugs in his room, but he did not think the red spots were bites.
-Staff changed his sheets that morning.

Second interview with the resident in room #37 on

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02/01/23 at 9:10am revealed he had never been asked to bag up his belongs or had his belongs bagged up for extermination treatments.

Observation of a second resident in room #37 on 01/31/23 at 11:00am revealed:
-There was a live bed bug on his box spring and 2 crawling on the wall above his bed.
-There were numerous bed bugs of varying sizes and spots of blood on his roommate's pillow and sheets.
-There were numerous dead bed bugs on the ceiling throughout the room.

Observation of the second resident bed in room #37 on 02/01/23 at 9:10am revealed there were numerous bed bugs in the corner of the mattress and box spring and blood spots and smears on the pillows of both beds.

Observation of the occupied resident room #40 on 02/01/23 at 8:52am revealed there were bed bugs on the walls and ceiling, there was clutter in the closet and corner of the room and food debris on the bed sheets.

Observation of the occupied resident room #42 on 02/01/23 at 9:07am revealed were bed bugs crawling on the walls, ceiling, and bed.

Observation of the occupied resident room #43 on 02/01/23 at 9:17am revealed:
-There were bed bugs in the seams of the mattress and the box spring.
-There were blood smears on the box spring.
-There was food debris on his bed sheets.

Interview with the resident in room #43 at 9:17am revealed:
-The resident reported seeing four roaches that

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morning.
-He frequently saw roaches in his dresser drawers.
-His belongings were never bagged up prior to treatment.

Observation of the occupied resident room #44 on 02/01/23 at 9:25am revealed there were bed bugs crawling on the mattress and sheets and food debris in the bed.

Observation of the occupied resident room #18 on the special care unit (SCU) at 8:50am revealed:
-There was a dead bed bug on the blanket on top of a resident's bed.
-There was a dresser with four drawers
-The top dresser drawer had two blue vinyl gloves in the drawer; one to the far right of the drawer and one in the middle of the drawer.
-The top dresser had one sock and one winter glove on top of excrement.
-The second dresser drawer contained 2 wigs, an opened 9 ounce bag of cookies, clothing items, an empty plastic sandwich bag, and an apple.
-There was debris and excrement scattered throughout the drawer and three areas of a brown sticky substance in the drawer.
-The third dresser drawer had several clothing items and an opened plastic sandwich bag with pecans.
-The drawer had mice and roach excrement scattered on the bottom of the drawer and there were 2 pecans sitting on top of an area of excrement.
-There was a nightstand by a resident's bed that had one drawer with excrement and mice droppings.
-The drawer had three tubes of lip balm lying on debris and excrement.

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D 079	Continued From page 8 Interview with a resident that resided in room #18 on 01/31/23 at 8:45am revealed: -She had not seen any bedbugs, roaches, or mice in her room. -She did not know when staff had last cleaned the dresser drawers or nightstand drawers in the room. Observation of the occupied resident room #19 on the SCU at 9:11am revealed: -There was a dead roach in the small refrigerator. -The refrigerator contained a sandwich wrapped in plastic wrap. Observation of the occupied resident room #20 on the SCU on 01/31/23 at 9:16am revealed: -There were mouse droppings and dead bedbugs on the box springs. -There were small areas of dried blood on the fitted sheet, flat sheet, and the pillowcase. Observation of the occupied resident room #21 on the SCU on 01/31/23 at 9:21am revealed there was a roach crawling on the bathroom wall. Interview with a resident that resided in room #21 on the SCU on 01/31/23 at 9:22am revealed she saw a roach on the bedroom wall above her bed before she observed the roach crawling on her bathroom wall. Observation of a nightstand in the occupied resident room #26 on the SCU on 01/31/23 at 9:33am revealed: -The top drawer had a holiday card that had mice droppings on top of the card and there were mice droppings scattered on the base of the drawer. -There were three individually wrapped snack cakes in the drawer and sealed packages of	D 079		

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crackers.
-There were three straws at the front of the drawer that had portions of the straw wrapper lying in the drawer.
-The second drawer had mice droppings throughout the base of the drawer and ¼ piece of an unwrapped cracker lying in the mouse droppings.

Interview with a resident that resided in room #26 on 01/31/23 at 9:30am revealed she had not noticed any bedbugs, roaches, or mice in her room.

Interview with the pest technician with the facility's contracted pest control company on 02/01/23 at 1:30pm revealed:
-He was contracted to treat the facility monthly for general pests and rodents which included bed bugs and roaches.
-His last visit to the facility was on 01/02/23 and he treated 9 rooms during that visit.
-The rooms he treated were based on the list of rooms with pest activity given to him by the administrator.
-The chemical he used for the treatment of bed bugs was residual meaning that it continued to kill over a period of time.
-The back hall of the assisted living side of the facility had more bed bugs than the other areas, rooms #8 and #4 on the front hall of the assisted living area and he did not think the SCU had any active pest activity.
-The facility was given a letter at the start of the contract for preparation prior to each treatment that included bagging resident belonging and drying, washing, and drying again the sheets and clothing.
-He did not know so many rooms in the facility still had active bed bug activity, but he thought the

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bed bugs were at a controllable level.
-Bed bugs were hard to eradicate and there were lots of places for them to hide in the facility.
-He had not been contacted by the facility to report continued pest activity.

Interview with a personal care aide (PCA) on 01/31/23 at 2:58pm revealed:
-Bed bugs had been a problem in the facility since she began working there approximately 1 year ago.
-The bed bugs were worse on the back hall of the assisted living (AL) side of the facility than the front hall and the special care unit (SCU).
-Three assisted living residents had bed bugs crawling on them in the dining room the previous Saturday.
-She saw mice on the SCU the previous Sunday in the residents' common sitting room.
-She saw a mouse in a resident room just that morning.
-Some residents complained about being woken up at night by the bed bugs and there were residents with bites on them especially in rooms #37 and #45.
-She reported resident concerns to the Administrator, and he said he would contact an exterminator to come out to treat the pests.
-She thought the exterminator treated monthly, but they only treated a few rooms at each visit.
-There was no preparation of resident rooms and belongings prior to treatment.

Interview with a medication aide (MA) on 01/31/23 at 8:45am revealed:
-She worked on the special care unit (SCU)
-The SCU had a problem with roaches and mice.
-There were mice droppings in resident rooms and she had seen roaches in resident rooms.
-She notified the Resident Care Coordinator

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(RCC) or Administrator on several occasions about mice and roaches on the SCU.
-The exterminator came to spray some rooms once a month.

Interview with a second MA on 02/01/23 at 4:15pm revealed:
-Bed bugs were throughout the building.
-There were 2 residents with lots of bites and scratches on them.

Interview with the Resident Care Coordinator (RCC) on 02/01/23 at 5:04pm revealed:
-Staff were expected to report any problems with bedbugs, roaches, or mice to either herself or the Administrator.
-The Administrator was the primary person responsible for environmental needs at the facility.
-The housekeeper and PCAs were responsible for checking all rooms for any sign of bedbugs, roaches, or mice daily; but staff did not routinely monitor for bedbugs or roaches daily.
-PCAs and the housekeeper changed resident linens on shower days, which was every other day.
-If the PCAs or housekeeper observed evidence of bed bugs they implemented a 14 day treatment plan.
-The 14 day treatment plan included drying, washing and then drying residents linens and clothes for 14 days.
-Th 14 day treatment plan was currently implemented for all rooms on the back hall of the assisted living unit.
-The facility was currently working on a 14 day treatment program to help decrease the bedbugs.
-The exterminator came to treat the facility one time a month.
-24 hours prior to the exterminator coming to treat

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the facility, staff were expected to assist residents pack up all of their belongings in plastic bags prior to their room being treated.
-The facility did not bag up all resident belongings in plastic bags prior to the exterminator coming to treat the rooms.
-Residents' belongings were not packed and bagged prior to treatment but were left in the drawers and closet.

Interview with the Administrator on 02/01/23 at 5:37pm revealed:
-The exterminator came to treat the facility once a month.
-When staff informed him that bed bug activity had been observed the housekeeper and PCAs implemented a 14 day treatment plan which included drying, washing and drying all resident linens and clothing.
-Housekeeping staff and PCAs were expected to also deep clean resident mattress, box springs, dresser drawers, floors and ceilings during the 14 day treatment.
-He expected the housekeeper and PCAs to ensure resident rooms were free from bug and rodent excrement.
-He notified the corporate office when there was a problem with pest control in the facility.

Telephone interview with the facility's contracted primary care provider (PCA) on 02/01/23 at 2:01pm revealed:
-She was not aware that residents had reported bed bugs in the facility and that some had been bitten from bed bugs.
-Residents were at risk of scratching their skin from bed bug bites which could lead to a bacterial infection in their skin from excessive scratching from bacteria under the residents' nails.
-Residents should reside in a clean environment

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LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 13	D 079		

to ensure they were not at risk of disease and infection from roaches, bed bugs and mice.
-Cleanliness was a problem and increased the risk of infection when pests were present in the environment.
-Mice feces could cause sickness from the Hantavirus which could cause muscle ache and fatigue.
-She would want to know about pests being present so she would know to watch for related sickness and treat quickly.

Telephone interview with the local health department's registered environmental health intern on 02/01/23 at 3:12pm revealed:
-Residents at the facility should be free from discomfort caused by any pests.
-Residents rooms and environment should be free from pests and any excrement left by pests.
-Roaches carried diseases and she had concerns about residents reporting live roaches in their environment because of the risk of disease.
-Residents were susceptible to itching, burning skin from bed bug bites and at further risk of infection if they scratched their skin with dirty fingernails.

_____

The facility failed to ensure the facility was clean and protected from hazards including bed bugs and roaches and their excrement, and mice droppings in resident rooms and common areas, several residents complained of bed bugs bites that caused irritation placing residents at risk of infection from bites and illness to susceptible residents at the facility. This failure was detrimental to the health, safety, and welfare of the resident's and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/31/23 for

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D 079	Continued From page 14 this violation.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 3 of 5 sampled residents (#1, #2, #5) related to a missed dental appointment (#1), failing to report bug bites to the primary care provider (PCP) (#2), and failing to report elevated blood pressures to the PCP (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 07/12/22 revealed: -Diagnoses included osteoarthritis, hypertension, and anxiety. -There was an order for Monodox 100mg twice daily 2 days before surgery (Monodox is an antibiotic). -There was an order for Peridex 0.12% hold 15 milliliters (mL) in closed mouth for 1 minute three times a day drain and avoid food or liquids for 30 minutes, begin 3 days before extraction (Peridex is an antibacterial mouthwash).	D 273		

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D 273	Continued From page 15 Interview with Resident #1 on 02/01/23 at 8:32am and 4:03pm revealed: -She had broken teeth that required surgery. -Her front teeth had been broken about a year. -Her broken teeth caused pain every day. -She had more pain when she ate. -She could only chew on the sides of her mouth due to her broken teeth. -She could only eat meats if they were soft enough so there were some meats she could not eat because of her broken teeth. -She had an appointment on 01/12/23 to have the teeth removed but the facility forgot to give her medications, so the appointment had to be canceled. -She did not know if she had a follow-up appointment to have her teeth removed. -She had been waiting since August 2022 to get her teeth fixed and her broken teeth were very painful. -Her dental appointment in August 2022 was canceled because of COVID-19. -She then had a dental appointment that was canceled because she had to see a cardiologist first. Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Monodox 100mg twice a day, begin 2 days before extractions scheduled for administration at 8:00am and 8:00pm. -Monodox 100mg was not documented as administered in January 2022. -There was an entry for Peridex 0.12% hold 15 mL in closed mouth for 1 minute 3 times a day, drain, and avoid food/liquids for 30 minutes, begin 3 days before extraction, please clarify surgery date. -Peridex 0.12% was not documented as	D 273		

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D 273	Continued From page 16 administered in January 2022. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/01/23 at 9:41am revealed: -Monodox 100mg was last filled for Resident #1 on 01/28/23. -There was a note that Resident #1 would need Monodox filled again on 04/18/23 due to a scheduled surgery. -Peridex 0.12% was last filled for Resident #1 on 07/21/22. Observation of Resident #1's medications on hand on 02/01/23 at 4:22pm revealed: -There was no Monodox on the medication cart for Resident #1. -There was no Peridex on the cart for Resident #1. Interview with a medication aide (MA) on 02/01/23 at 9:13am revealed: -Resident #1 had orders to receive antibiotics before her dental appointment. -The pharmacy was supposed to put the order into the system so that it showed up on the eMAR. -She thought the transportation coordinator faxed the appointment dates to the pharmacy. -The pharmacy must have placed the medication dates on the eMAR wrong. -She did not think the facility ever received Resident #1's antibiotic from the pharmacy but if they did, they had sent it back because it was sent on the wrong date. -She did not know Resident #1 was supposed to receive the medication earlier in January. -She did not know anything about Resident #1 needing Peridex before surgery as well.	D 273		

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D 273	Continued From page 17 Interview with the transportation coordinator on 02/01/23 at 1:10pm revealed: -He took residents to all medical appointments. -He scheduled most medical appointments for residents but sometimes residents scheduled their own appointments and made him aware of them. -Resident #1 was supposed to have oral surgery sometime in January but he was not sure of the date. -The day before Resident #1's oral surgery that was scheduled in January 2022 he told a MA that Resident #1 had a dental appointment the next day. -The MA told him Resident #1 had medication she was supposed to receive prior to going to the dentist and she had not received them. -He did not remember who the MA was. -Because Resident #1 did not receive her medication he called and canceled her dental appointment. -Another dental appointment was scheduled for Resident #1 in April 2022 because that was the earliest appointment the dentist had. -MAs should have known that Resident #1 had the dental appointment because he made copies of all the resident's appointments and gave one to the MAs, the Resident Care Coordinator (RCC), and the resident's primary care provider (PCP). Telephone interview with a staff member at Resident #1's dental office on 02/01/23 at 3:00pm revealed: -Resident #1 had an appointment on 01/12/23 that was canceled. -She was not sure why the appointment was canceled. -Resident #1's appointment had been rescheduled for 04/20/23.	D 273		

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D 273	Continued From page 18 Interview with the RCC on 02/01/23 at 5:07pm revealed: -The transportation coordinator attended all medical appointments with residents. -When the transportation coordinator returned from medical appointments, he should make the MAs aware of any follow up appointments by telling them as well as giving the MA a copy of the medical appointment. -If a resident had a medical appointment scheduled and needed medication prior to that appointment the MA should fax the appointment information to the pharmacy so the pharmacy could put the medication on the eMAR. -There was no one MA in charge of making sure the appointment dates got sent to the pharmacy. -The RCC also received a copy of all resident appointments. -She knew Resident #1 needed to have a dental procedure done so she could get dentures. -She did not know that Resident #1 had missed her dental procedure because she did not get her medication beforehand. Interview with the Administrator on 02/01/23 at 4:07pm and 5:36pm revealed: -If a resident had medications ordered prior to an appointment the MA should make the RCC aware and the RCC should make him aware. -MAs knew when residents had appointments because the transportation schedule with resident appointments was posted in the medication room and by the time clock. -He was not aware that Resident #1 was supposed to receive medications prior to her dental appointment. -He was not aware that Resident #1 had missed her scheduled dental appointment. -He expected Resident #1 to receive her medications as ordered prior to her dental	D 273		

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appointment so she could attend her appointment.

Telephone interview with Resident #1's primary care provider (PCP) on 02/01/23 at 1:56pm revealed:
-Resident #1 had a long-standing issue with her mouth and teeth.
-One of her previous dental appointments was canceled due to COVID-19 and another one had been canceled because she needed cardiac clearance beforehand.
-She was not aware that Resident #1 missed her most recent dental appointment to have her broken teeth removed.
-Resident #1's dentist had ordered prophylaxis medications to be given prior to her dental procedure.
-She had made sure to put the prophylaxis medications on Resident #1's FL-2 and expected the facility to make arrangements for the resident to get her medications prior to her scheduled dental appointment.
-Resident #1 had been waiting a long time to get her teeth removed and it was not fair to the resident that she had to wait longer because the facility had to cancel her appointment.

Attempted telephone interview with Resident #1's dentist on 02/01/23 at 3:00pm was unsuccessful.

2. Review of Resident #2's current FL-2 dated 07/12/22 revealed:
-Diagnoses included uncontrolled diabetes and acute encephalopathy.
-There was no documentation of orientation status.

Observation of Resident #2 on 01/31/23 at 10:50am revealed there were numerous red

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spots, scratches and scabs on his upper and lower extremities.

Interview with Resident #2 on 01/31/23 at 10:50am revealed:
-He scratched his arms and legs because they were always itching.
-He had seen bed bugs in his room, but he did not think the red spots were bites.
-Staff changed his sheets that morning.

Observation of Resident #2's bedroom on 01/31/23 at 11:00am revealed:
-There was a live bed bug on his box spring and 2 crawling on the wall above his bed.
-There were numerous bed bugs of varying sizes and spots of blood on his roommate's pillow and sheets.
-There were numerous dead bed bugs on the ceiling throughout the room.

Review of Resident #2's progress notes on 02/01/23 revealed there was no documentation of notification to the Primary Care Provider (PCP) of itching or scratching.

Review of Resident #2's Skin Monitoring Comprehensive Certified Nurse Aide (CNA) Shower Review sheet dated 01/02/23 revealed:
-There was documentation he refused the visual assessment 4 times.
-There was no documentation of red areas or scratches.
-It was signed by the supervisor on 01/02/23 and by the Resident Care Coordinator (RCC) on 01/03/23

Review of Resident #2's Skin Monitoring Comprehensive Shower Review sheet dated 01/04/23 revealed:

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D 273	Continued From page 21 -There was documentation he refused the visual assessment 3 times. -There was no documentation of red areas or scratches. -It was signed by the supervisor on 01/04/23 and by the RCC on 01/05/23. Review of Resident #2's Skin Monitoring Comprehensive Shower Review sheet dated 01/13/23 revealed: -There was documentation he refused the visual assessment 4 times. -There was no documentation of red areas or scratches. -It was signed by the supervisor on 01/13/23 and by the RCC on 01/14/23. Review of Resident #2's Skin Monitoring Comprehensive Shower Review sheet dated 01/16/23 revealed: -There was documentation he refused the visual assessment and said that he would do it in the morning. -There was no documentation of red areas or scratches. -It was signed by the supervisor on 01/16/23 and by the RCC on 01/16/23. Review of Resident #2's second Skin Monitoring Comprehensive Shower Review sheet dated 01/16/23 revealed: -There was documentation his linen was changed, bed was made, laundry and assisted with shower. -There was no documentation of red areas or scratches. -It was signed by the supervisor on 01/16/23 and by the RCC on 01/16/23. Review of Resident #2's Skin Monitoring	D 273		

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D 273	Continued From page 22 Comprehensive Shower Review sheet dated 01/20/23 revealed: -There was documentation he refused the visual assessment 3 times. -There was no documentation of red areas or scratches. -It was signed by the supervisor on 01/20/23 and by the RCC on 01/21/23. Review of Resident #2's Skin Monitoring Comprehensive Shower Review sheet dated 01/23/23 revealed: -There was documentation he refused the visual assessment 3 times. -There was no documentation of red areas or scratches. -It was signed by the RCC on 01/23/23. Review of Resident #2's second Skin Monitoring Comprehensive Shower Review sheet dated 01/23/23 revealed: -There was documentation his linen was changed, bed was made, laundry and assisted with shower. -There was no documentation of red areas or scratches. -It was signed by the supervisor on 01/23/23 and by the RCC on 01/23/23. Interview with a Personal Care Aide (PCA) on 01/31/23 t 2:58pm revealed: -Bed bugs had been present in the facility for as long as she could remember. -Residents' families have complained about bed bugs in the past. -Resident #2 had bed bug bites and scratched his skin a lot but he denied being bit because he was confused. -All staff were aware of the scratches and bites on Resident #2.	D 273		

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-Many residents had complained of being woken during the night because of bed bugs.
-The Administrator was aware of the bed bugs in the facility and was in Resident #2's room the previous week while care staff and housekeeping staff were vacuuming bed bugs off the ceiling.

Interview with the Medication Aide (MA) on 02/01/23 at 4:15pm revealed:
-Resident #2 and another resident room had more bed bugs than the rest of the resident rooms.
-Resident #2 had bites and scratches on his body.
-She thought the PCP was aware of the bites and scratches but she could not remember if she had reported the bites and scratches or not.
-Resident #2 did not have any treatment prescribed for any skin condition or itching.

Telephone interview with Resident #2's PCP on 02/01/23 at 1:55pm revealed:
-She was not made aware of the bed bugs in his bedroom or the scratches on Resident #2's arms and legs.
-Scratching could cause infection by introducing bacteria into the scratch.
-Resident #2 was at an increased risk of infection because he was diabetic and his blood sugars were not well controlled due to his non-compliance with treatment and monitoring efforts.
-She was aware Resident #2 would often refuse showers and only allowed limited assessment but she expected the facility to notify her of any skin issues so she could prescribe treatment.

Interview with the Resident Care Coordinator (RCC) on 02/01/23 at 5:00pm revealed:
-Skin assessments were completed 3 times per

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week on the days residents received a shower.
-Resident #3 was scheduled to receive his shower on 3rd shift and would usually refuse.
-She reviewed the skin assessments but, since Resident #2 typically refused his shower, his skin assessment would indicate he refused so she was not aware of any skin concerns.
-She would have notified Resident #2's PCP if she had known.

Interview with the Administrator on 02/01/23 at 5:36pm revealed:
-Notifications to the provider were to be documented on a progress note in the resident record.
-The care staff completed skin assessments on resident shower days and the RCC was responsible for reviewing the skin assessments and notifying the PCP if it was needed.
-He would have expected the PCP to be notified of Resident #2's itching and scratching no matter the cause.

3. Review of Resident #5's current FL-2 dated 12/08/22 revealed diagnoses included history of congestive heart failure, type 2 diabetes, and dementia.

Review of Resident #5's physician order sheet dated 05/04/22 revealed there was an order to monitor blood pressure (BP) daily and report systolic BP of greater than 175.

Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for check BP daily and report to primary care provider (PCP) if systolic BP is greater than 175 scheduled for 7:00am to 3:00pm.

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D 273	Continued From page 25 -Resident #5's BP on 12/15/22 was 199/99. -Resident #5"s BP on 12/16/22 was 189/90. Review of Resident #5's progress notes revealed there was no documentation that Resident #5's primary care provider (PCP) had been notified of his elevated systolic BPs on 12/15/22 or 12/16/22. Interview with a medication aide (MA) on 02/01/23 at 4:00pm revealed: -MAs performed BP checks on residents if ordered. -If a resident had orders to report elevated BPs to the PCP it should be done and documented in the resident's progress notes. Interview with the Resident Care Coordinator (RCC) on 02/01/23 at 5:07pm revealed: -She expected MAs to report elevated BPs on residents as ordered by the PCP. -If a MA reported an elevated BP to the PCP, it should be documented in the resident's progress notes. Interview with the Administrator on 02/01/23 at 5:36pm revealed: -It was important to follow all PCP orders. -Elevated BPs should be reported by a MA to a resident's PCP as ordered. -If a MA reported an elevated BP to a PCP, it should be documented in the resident's progress notes. Telephone interview with Resident #5's PCP on 02/01/23 at 1:56pm revealed: -She expected facility staff to report elevated BPs on Resident #5 as ordered. -She did not recall being notified by the facility of any elevated BPs for Resident #5.	D 273		

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D 273	Continued From page 26 -If she had been notified by the facility that Resident #5 had an elevated BP, she would have looked at his ordered medications to see if any of his blood pressure medications could be given earlier in the day to lower his BP. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. _____ The facility failed to ensure that a resident attended a scheduled dental appointment (#1) for which the resident was experiencing daily mouth pain and having difficulty eating in which the resident had to wait 3 months for another appointment and failed to report bug bites and scratches to the primary care provider (PCP) on a resident (#2) for which she would have prescribed treatment. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/01/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 18, 2023.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1, #5) related to a resident failing to receive ordered antibiotic medications (#1) and a resident failing to receive insulin (#5).

The findings are:

1. Review of Resident #1's current FL-2 dated 07/12/22 revealed:
-Diagnoses included osteoarthritis, hypertension, and anxiety.
-There was an order for Monodox 100mg twice daily 2 days before surgery (Monodox is an antibiotic).
-There was an order for Peridex 0.12% hold 15 milliliters (mL) in closed mouth for 1 minute three times a day drain and avoid food or liquids for 30 minutes, begin 3 days before extraction (Peridex is an antibacterial mouthwash).

Interview with Resident #1 on 02/01/23 at 8:32am revealed:
-She had broken teeth that required surgery.
-She had an appointment on 01/12/23 to have the teeth removed but the facility forgot to give her medications, so the appointment had to be canceled.

Review of Resident #1's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Monodox 100mg twice a day, begin 2 days before extractions scheduled

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for administration at 8:00am and 8:00pm.
-Monodox 100mg was not documented as administered in January 2022.
-There was an entry for Peridex 0.12% hold 15 mL in closed mouth for 1 minute 3 times a day, drain, and avoid food/liquids for 30 minutes, begin 3 days before extraction, please clarify surgery date.
-Peridex 0.12% was not documented as administered in January 2022.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/01/23 at 9:41am revealed:
-Monodox 100mg was last filled for Resident #1 on 01/28/23.
-There was a note that Resident #1 would need the medication filled again on 04/18/23 due to a scheduled surgery.
-Peridex 0.12% was last filled for Resident #1 on 07/21/22.

Observation of Resident #1's medications on hand on 02/01/23 at 4:22pm revealed:
-There was no Monodox on the medication cart for Resident #1.
-There was no Peridex on the medication cart for Resident #1.

Interview with a medication aide (MA) on 02/01/23 at 9:13am revealed:
-Resident #1 had orders to receive antibiotics before her dental appointment.
-The pharmacy was supposed to put the order into the system so that it showed up on the eMAR.
-She thought the transportation coordinator faxed the appointment dates to the pharmacy.
-The pharmacy placed the medication on the eMAR wrong.

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-She did not think the facility ever received Resident #1's antibiotic from the pharmacy but if they did, they had sent it back because it was sent on the wrong date.
-She did not know Resident #1 was supposed to receive the medication earlier in January.
-She did not know anything about Resident #1 needing Peridex before surgery as well.

Interview with the transportation coordinator on 02/01/23 at 1:10pm revealed:
-Resident #1 was supposed to have oral surgery sometime in January but he was not sure of the date.
-The day before Resident #1's oral surgery that was scheduled in January 2022 he told a MA that Resident #1 had a dental appointment the next day.
-The MA told him Resident #1 had medication she was supposed to receive prior to going to the dentist and she had not received them.
-He did not remember who the MA was.
-MAs should have known that Resident #1 had the dental appointment because he made copies of all the resident's appointments and gave one to the MAs, the Resident Care Coordinator (RCC), and the resident's primary care provider (PCP).

Interview with the RCC on 02/01/23 at 5:07pm revealed:
-If a resident had a medical appointment scheduled and needed medication prior to that appointment the MA should fax the appointment information to the pharmacy so the pharmacy could put the medication on the eMAR.
-There was no one MA in charge of making sure the appointment dates got sent to the pharmacy.
-The RCC also received a copy of all resident appointments.
-She knew Resident #1 needed to have a dental

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procedure done so she could get dentures.
-She did not know that Resident #1 had missed her dental procedure because she did not get her medication beforehand.

Interview with the Administrator on 02/01/23 at 4:07pm and 5:36pm revealed:
-If a resident had medications ordered prior to an appointment the MA should make the RCC aware and the RCC should make him aware.
-MAs knew when residents had appointments because the transportation schedule with resident appointments was posted in the medication room and by the time clock.
-He was not aware that Resident #1 was supposed to receive medications prior to her dental appointment.
-He expected Resident #1 to receive her medications as ordered prior to her dental appointment so she could attend her appointment.

Telephone interview with Resident #1's primary care provider (PCP) on 02/01/23 at 1:56pm revealed:
-Resident #1's dentist had ordered prophylaxis medications to be given prior to her dental procedure.
-She had made sure to put the prophylaxis medications on Resident #1's FL-2 and expected the facility to make arrangements for the resident to get her medications prior to her scheduled dental appointment.

Attempted telephone interview with Resident #1's dentist on 02/01/23 at 3:00pm was unsuccessful.

2. Review of Resident #5's current FL-2 dated 12/08/22 revealed diagnoses included type 2 diabetes.

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D 358	Continued From page 31 Review of Resident #5's physician order sheet dated 12/13/22 revealed there was an order for Basaglar inject 30 units at bedtime, hold for fingerstick blood sugar (FSBS) less than 100 (Basaglar is used to lower blood sugars). Review of Resident #5's December 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Basaglar inject 30 units every night at bedtime scheduled for 8:00pm. -There was an entry for FSBS four times a day scheduled for 6:00am, 11:00am, 5:00pm, and 8:00pm. -There was a notation that Resident #5 was out of the facility 11/25/22 to 12/09/22. -Basaglar was documented as administered at 8:00pm on 12/09/22, 12/11/22, 12/15/22 to 12/17/22, 12/19/22, 12/24/22 to 12/25/22, and 12/27/22. -On 12/10/22, FSBS was documented as 113 at 8:00pm and Basaglar was documented as held per primary care provider (PCP) orders. -On 12/12/22, FSBS was documented as 128 at 8:00pm and Basaglar was documented as held per PCP orders. -On 12/18/22, Basaglar was documented as refused. -On 12/20/22, FSBS was documented as 112 at 8:00pm and Basaglar was documented as held per PCP orders. -FSBS was documented as 163 on 12/22/22 and 107 on 12/23/22 at 8:00pm and on 12/22/22 to 12/23/22, Basaglar was documented as held per PCP orders. -On 12/26/22, FSBS was documented as 111 at 8:00pm and Basaglar was documented as held per PCP orders. -FSBS was documented as 132 on 12/28/22, 164	D 358		

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on 12/29/22, 159 on 12/30/22, and 123 on 12/31/22 at 8:00pm and on 12/28/22 to 12/31/22, Basaglar was documented as held per PCP orders.
-Resident #5's Basaglar was held 10 times in December 2022 when it should have been administered.

Review of Resident #5's December 2022 progress notes revealed at 8:00pm on 12/20/22 there was a notation by a medication aide (MA) "insulin held due to parameters".

Review of Resident #5's January 2023 eMAR revealed:
-There was an entry for Basaglar inject 30 units every night at bedtime scheduled for 8:00pm.
-There was an entry for FSBS four times a day scheduled for 6:00am, 11:00am, 5:00pm, and 8:00pm.
-Basaglar was documented as administered 01/01/23 to 01/03/23, 01/06/23 to 01/10/23, 01/12/23 to 01/15/23, 01/18/23, 01/23/23, 01/26/23, and 01/28/23.
-FSBS was documented as 111 on 01/04/23 and 119 on 01/05/23 at 8:00pm and on 01/04/23 to 01/05/23, Basaglar was documented as held per PCP orders.
-On 01/11/23, FSBS was documented as 130 at 8:00pm and Basaglar was documented as held per PCP orders.
-FSBS was documented as 129 on 01/16/23 and 113 on 01/17/23 at 8:00pm and on 01/16/23 to 01/17/23 Basaglar was documented as held per PCP orders.
-On 01/20/23, FSBS was documented as 129 at 8:00pm and Basaglar was documented as held per PCP orders.
-On 01/22/23, FSBS was documented as 131 at 8:00pm and Basaglar was documented as held

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per PCP orders.
-On 12/27/23, FSBS was documented as 102 at 8:00pm and Basaglar was documented as held per PCP orders.
-FSBS was documented as 117 on 01/29/23 and 120 on 01/30/23 at 8:00pm and on 12/29/23 to 12/30/23, Basaglar was documented as held per PCP orders.
-Resident #5's Basaglar was held 10 times in January 2023 when it should have been administered.

Review of Resident #5's January 2023 progress notes revealed:
-At 8:00pm on 01/13/23 there was a notation by a MA "insulin held due to parameter 130".
-At 8:00pm on 01/17/23 there was a notation by a MA "glargine insulin withheld due to parameter 103" (Glargine insulin is the same as Basaglar).
-At 8:00pm on 01/27/23 there was a notation by a MA "blood sugar registered 103 held glargine insulin due to parameter".
-At 8:00pm on 01/30/23 there was a notation by a MA "glargine held due to parameter".

Interview with a MA on 02/01/23 at 4:00pm revealed:
-It was important for all residents to receive medications as ordered.
-Resident #5's insulin should not have been held unless his FSBS was outside of parameters or if the primary care provider (PCP)gave the MA permission to hold the insulin for another reason.
-If a MA had received permission from the PCP to hold Resident #5's insulin it should be documented in the resident's progress notes.

Interview with the Resident Care Coordinator (RCC) on 02/01/23 at 5:07pm revealed:
-She was not aware that Resident #5 had missed

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D 358	Continued From page 34 doses of insulin. -She expected MAs to read Resident #5's medication orders thoroughly and be able to follow directions for withholding insulin. -It was important that Resident #5 receive his insulin as ordered. Interview with the Administrator on 02/01/23 at 5:36pm revealed he expected Resident #5 to receive insulin as ordered. Interview with Resident #5's PCP on 02/01/23 revealed: -She had been battling blood sugars with Resident #5 and had been titrating his insulin based on his blood sugar results. -She had not noticed that Resident #5's blood sugars had been running any differently than usual. -She expected Resident #5 to get insulin as ordered. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable. Attempted telephone interview with a MA on 02/01/23 at 4:17pm was unsuccessful.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.	D 466		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure there was a care coordinator on the special care unit (SCU) with a census of 25 residents for 8 hours per day 5 days per week.

The findings are:

Review of the facility's current license effective 01/01/23 revealed the facility was licensed for a capacity of 94 beds including 62 beds for the assisted living (AL) area and 32 beds for the special care unit (SCU).

Review of the facility's resident census reports provided on 01/31/23 revealed:
-The facility's in house census was 60 residents.
-There were 35 residents residing on the AL side of the facility.
-There were 25 residents residing on the SCU.

Observations of the SCU on 01/31/23 from 8:29am to 9:39am revealed there were 2 personal care aides (PCAs) and 1 medication aide (MA) on duty for first shift.

Observations of the SCU on 01/31/23 at 3:16pm revealed there were 2 PCAs and 1 MA on duty for second shift.

Observation of the SCU on 02/01/23 at 10:00am revealed there were 2 PCAs and 1 MA on duty for first shift.

Interview with a personal care aide (PCA) on the Special Care Unit (SCU) on 01/31/23 at 8:29am revealed:

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D 466	Continued From page 36 -The SCU did not have a SCU Coordinator. -She had worked at the facility for two years and the SCU had never had a SCU Coordinator. -The Resident Care Coordinator (RCC) for the Assisted Living (AL) unit would walk through the SCU a few times a week; however the SCU only had medication aides (MAs) and PCAs working on the SCU. -She had not seen the RCC enter the SCU today. Interview with a medication aide (MA) on the SCU on 01/31/23 at 8:40am revealed: -There was not a SCU Coordinator designated to work on the SCU. -The RCC would walk through the SCU at the most three times a week to tour the unit. -The SCU staff included a MA and PCAs to provide care to residents. -The Activity Coordinator was on the SCU several times a week. Interview with a second MA on the SCU on 02/01/23 at 2:51pm revealed: -There was not a SCU coordinator. -The RCC would bring her laptop cart a few times a week to the SCU to look at residents and speak with staff. -She had been on the SCU today since 7:00am and had not seen the RCC on the SCU. Observation of the RCC on 01/31/23 at 3:55pm revealed she was in the medication room on the AL unit. Interview with the RCC on 01/31/23 at 4:00pm revealed: -She was the RCC for the AL and the SCU. -The facility did not have a staff person hired specifically for the SCU to provide 8 hours a day, five days a week on the SCU.	D 466		

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-She was responsible for supervising MAs and PCAs on the SCU and the AL unit.
-She was responsible for any follow up with resident's primary care physicians (PCPs), appointments, FL-2s, updating resident care plans and scheduling staff.
-Her office was located on the back hall of the AL unit.
-She did not have an office on the SCU.
-Most days she worked from the Business Office Managers (BOM) office where staff could see her if they needed her.
-She spent time observing the AL unit and SCU going back and forth.
-She was out of the facility each Monday from 6:30am to 12:00pm and some Mondays from 6:30am-3:00pm.
-She worked partial days on Tuesdays and Wednesdays.
-When she was not in the facility the Administrator was in charge of the AL unit and SCU.
-She tried to pick a weekend day to work to ensure she had 40 hours a week at the facility.

Interview with the Administrator on 02/01/23 at 5:51pm revealed:
-He was the contact person for the MAs when the RCC was not in the building.
-He covered the RCC role when she was working on the SCU, but he could not provide an estimated number of hours he covered the RCC role.
-When staff had a concern or issue with a resident, they would always contact him and the RCC.
-The facility had not hired a SCU coordinator because he thought the RCC was responsible for that unit as well.
-The facility had not hired a SCU coordinator that

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D 466	Continued From page 38 was on the SCU 8 hours a day for 5 days a week. -He felt that the MAs and PCAs were well trained and would inform him if there was a resident need when the RCC was not in the facility. -The MAs knew when they should contact the primary care physician (PCP) if needed. -The MAs would follow up with him and the RCC if there was a concern about a resident.	D 466		