STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 conducted an annual and follow-up survey August 9, 2023 to August 11, 2023.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any	C 007		

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C 007	Continued From page 1 possible changes that may be required to the building. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the census in the facility did not exceed the license capacity. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for a capacity of six ambulatory residents, three of the six residents could be non-ambulatory. Observation of the facility on 08/09/23 at 7:30am revealed: -There were two entrances to the facility. -There was a small front porch with steps and a wheelchair ramp that led to the front yard. -There was small covered back porch with a wheelchair ramp that led to the side yard. Observation of the facility on 08/10/23 at 4:32pm revealed: -There were two bedrooms and a bathroom at the back of the facility. -The MA/Administrator entered her elderly family member's bedroom. -The MA/Administrator assisted her elderly family member sit up on the side of the bed. Interview with the medication aide (MA)/Administrator on 08/09/23 at 7:15am revealed:	C 007		

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C 007	Continued From page 2 -The facility's current census was six residents. -All six residents were independent, ambulated independently and were alert and oriented. Interview with the Administrator on 08/11/23 at 4:30pm revealed she paid a sitter to come at least three days a week to provide personal care to her elderly family member. Observation of a fire drill on 08/10/23 between 4:27pm to 4:35pm revealed: -There were five residents sitting in the living room, one male resident in his bedroom with the door closed adjoined to the living room, and staff's elderly family member in a back bedroom of the home. -The MA/Administrator sounded the alarm in the living room at 4:27pm creating a loud beeping sound. -The fire alarm was audible throughout the entire facility. -The five residents sitting in the living room stood up and immediately exited the home through the front door and waited in the front yard. -The resident in the bedroom adjacent to the living room had not opened his door. -The MA/Administrator told the resident that this was a fire drill and he had to evacuate the home. -The resident was on his bed, awake and refusing to get out of his bed. -The male resident exited the home at 4:30pm. -The state surveyor asked the MA/Administrator if there was anyone else in the home and the MA/Administrator asked if she needed to go get her elderly family member. -She was instructed again that all individuals in the home needed to evacuate during the facility fire drill. -The MA/Administrator was observed opening the back bedroom door of her elderly family member.	C 007		

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C 007	Continued From page 3 -The MA/Administrator's elderly family member was asleep on the bed and the MA/Administrator had to wake the family member up. -The MA/Administrator was observed assisting her elderly family member to sit up on the edge of the bed and provided her assistance with walking from the bedroom to the back door. -The MA/Administrator provided the elderly family member with a walker to use and the MA/Administrator held onto the walker and walked in front of the family member prompting her to continue walking down toward the ramp and to exit the building. -The MA/Administrator had to move several items on the porch to make a path for the elderly family member to ambulate to the wheelchair ramp. -At 4:35pm, the MA/Administrator had assisted the elderly family member with a walker to ambulate to the end of the wheelchair ramp on the side of the home. Interview with the MA/Administrator on 08/10/23 at 4:40pm revealed: -She had an elderly family member that lived at the facility. -She did not consider her elderly family member a resident at the home. -When she held fire drills, her family member was usually at the home to assist their elderly family member out of the home during fire drills. -The elderly family member was able to ambulate independently, however she had just woken up and needed assistance today during the fire drill. -She explained that with the amount of time it took her to assist her elderly family member to safely evacuate the home and the prompting it took for a resident whose bedroom was at the living room that "all of us would be dead" if this had been a real fire. -She had not thought about the possibility that	C 007		

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C 007	Continued From page 4 she may not be able to assist her elderly family member out of the home if she were injured.	C 007		
C 077	10A NCAC 13G .0315(a)(4) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the facility had an approved North Carolina Division of Environmental Heath sanitation classification at all times as required. The findings are: Observation during a tour of the facility on 08/09/23 revealed the last county sanitation inspection was completed 04/21/21 with no points deducted. Interview with the medication aide (MA)/Administrator on 08/09/23 at 10:58am revealed she thought the county Environmental Health came to inspect the home in 2022 but she could not locate the paperwork. Observation of the most recent county sanitation inspection on 08/10/23 revealed: -The most recent county sanitation inspection	C 077		

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C 077	Continued From page 5	C 077		

was completed on 03/29/22.
-There were no points deducted from the sanitation inspection report dated 03/29/22.

Interview with the MA/Administrator on 08/10/23 at 12:12pm revealed:
-There had not been a sanitation inspection of the facility since 03/29/22.
-She had not called the county Environmental Health office to schedule the facility for a sanitation inspection because she did not know she was supposed to call to schedule the inspection.
-In previous years she thought they just came each year when they were ready.
-She did not realize she should have contacted the county Environmental Health office until the state surveyor informed her today.

Review of an Environmental Health report dated 08/11/23 for the facility revealed:
-There were 18 total demerits, and the facility received a provisional status.
-There were 6 demerits for sewage and other liquid wastes disposed of by approved method; the washing machine was straight piped into a storm drain.
-There were 4 demerits for an excessive amount of live and dead roaches in the kitchen, evidence of mice droppings in the kitchen cabinets, and evidence of bedbugs on a resident's mattress.
-There were 4 demerits for substances containing poisonous material not used for cleaning or polishing eating or cooking utensils, the stove had a drawer that did not work properly and was not cleaned regularly, the refrigerator needed to be deep cleaned, chemicals were stored with food products, and utensils were not stored and considered clean, utensils were in a dirty drawer and were not clean to sight.

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C 077	Continued From page 6 -There were 2 demerits for improper storage of chemicals, cleaning supplies and pesticides; they were stored with food products. -There were 2 demerits for bed linens that were washed in an outdoor laundry room, linens were outside on the ground in the laundry room and outside on grass. -There was a notation that air conditioners should be cleaned and free from dust, floors need to cleaned regularly and throughout the home, clean bathtubs regularly to prevent buildup, food in freezer and refrigerator should be covered and protected, and open food should not be reserved when cooked for an individual or prepared for an individual. Attempted telephone interview with the environmental health specialist on 08/11/23 at 4:15pm was unsuccessful. _____ The facility failed to ensure there was an approved North Carolina Division of Environmental Health sanitation classification as evidenced by a provisional classification issued by the local environmental health department on 08/11/23. This failure was detrimental to the health, safety, and welfare of the 6 residents residing in the facility and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2023.	C 077		

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C 078	Continued From page 7	C 078		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain an environment that was clean and free from hazards as evidenced by an active infestation of roaches and bedbugs throughout the facility and cleaning agents and insecticides which could be hazardous were kept in a separate locked area. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 6 residents including three non-ambulatory residents. Interview with the medication aide (MA)/Administrator on 08/09/23 at 7:11am revealed 6 residents lived at the facility and her elderly family member. Review of an Environmental Health report dated 08/11/23 for the facility revealed:	C 078		

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C 078	Continued From page 8 -The facility received a provisional status with a demerit score of 18. -6 points were deducted for sewage and other liquid wastes disposed of by approved method; the washing machine was straight piped into a storm drain. -4 points were deducted for excessive amount of live and dead roaches in the kitchen, evidence of mice droppings in the kitchen cabinets, and evidence of bedbugs on a resident's mattress. -4 points were deducted for substances containing poisonous material not used for cleaning or polishing eating or cooking utensils. -The stove had a drawer that did not work properly and was not cleaned regularly. -The refrigerator needed to be deep cleaned. -Utensils were not stored and considered clean, utensils were in a dirty drawer and were not clean to sight. -Chemicals were stored with food products on the kitchen counters and in the kitchen cabinets. -2 points were deducted for improper storage of chemicals, cleaning supplies and pesticides; they were stored with food products. -2 points were deducted for bed linens that were washed and on the floor in an outdoor laundry room, linens were outside on the ground that had fallen off of a clothesline. -Additional comments on the report included air conditioners should be cleaned and free from dust, floors need to cleaned regularly and throughout the home, clean bathtubs regularly to prevent buildup, food in freezer and refrigerator should be covered and protected, and open food should not be reserved when cooked for an individual or prepared for an individual. Observations of the facility on 08/09/23 from 7:30am to 10:27am revealed: -There were two adult roaches crawling in the	C 078		

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C 078	Continued From page 9	C 078		

bathtub.
-There was one dead roach under the corner of a cutting board on the kitchen counter to the right of the stove.
-Two small roaches were crawling on the dining room table.
-There was roach excrement on linens that covered the buffet and dresser in the dining room.
-There were two dead roaches in a trashcan with no trash bag in the dining room.
-There were five fly swatters in a chair in the living room.

Observations of the dining room and kitchen on 08/11/23 from 9:53am to 12:38pm revealed:
-There was an adult roach that crawled out of a three ring binder onto the dining room table when the state surveyor picked up the binder.
-An adult roach crawled under a picture frame on the dining room wall.
-An adult roach crawled up the wall of the dining room.
-An adult roach crawled down the doorway entrance from the dining room to the kitchen.
-Two adult roaches and one small roach crawled across the dining room wall and under picture frames.
-An adult roach crawled across the stove.

Observation of the kitchen on 08/10/23 at 4:41pm revealed there was an adult roach that crawled on the counter to the left of the refrigerator, the state surveyor informed the MA/Administrator, and she sprayed an insecticide on the roach in an attempt to kill it.

Observation of the kitchen counter to the right to the stove on 08/09/23 at 7:55am revealed:
-There was a 16.5 ounce aerosol container of roach, ant, and spider spray with a warning to

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C 078	Continued From page 10 keep out of reach of children, keep away from heat, store in a well ventilated place, if breathing difficulties, remove victim to fresh air and keep at rest in a position comfortable for breathing, get medical attention if a person felt unwell, avoid contact with skin and eyes, avoid breathing mist, and when using do not eat, drink or smoke. -There was one 17.5 ounce aerosol container of ant and roach spray with a warning to keep out of reach of children, keep away from heat, store in a well ventilated place, if breathing difficulties, remove victim to fresh air and keep at rest in a position comfortable for breathing, get medical attention if a person felt unwell, avoid contact with skin and eyes, avoid breathing mist, and when using do not eat, drink or smoke. Observation of the kitchen counter to the right of the sink on 08/09/23 at 7:58am revealed there was a 17.5 ounce aerosol spray container of roach spray with a warring to keep out of reach of children, keep away from heat, store in a well ventilated place, if breathing difficulties, remove victim to fresh air and keep at rest in a position comfortable for breathing, get medical attention if a person felt unwell, avoid contact with skin and eyes, avoid breathing mist, and when using do not eat, drink or smoke. Observation of the kitchen counter to the left of the refrigerator on 08/09/23 at 7:59am revealed: -There was a one quart of ready to use, intermediate level, one step cleaner and disinfectant on the second shelf with a warning to wash hands and any exposed skin after handling, if skin or eye contact get medical attention, if inhalation remove victim to fresh air and keep at a rest position for comfortable breathing, call a poison control center or physician if a person felt unwell.	C 078		

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C 078	Continued From page 11 -There was a one quart bottle of purple multipurpose cleaner uncovered with a warning to not drink the product, avoid contact with skin and eyes, avoid smoking, eating or drinking in the application area, and keep container tightly closed for safe storage. Review of consumerreports.org revealed that on 02/08/23 the purple liquid multipurpose cleaner was recalled due to it containing pseudomonas species bacteria (pseudomonas species bacteria which are environmental organisms found widely in soil and water), the recall warned that people with weakened immune systems, external medical devices, or underlying lung conditions who are exposed to the bacteria face a risk of serious infection that may require medical treatment and the bacteria can enter the body if inhaled, through the eyes, or through a break in the skin. Observation of the kitchen floor on 08/09/23 from 8:00am to 8:08am revealed: -There were three dead roaches on the kitchen floor. -There was a white towel pushed under the front of the right side of the stove drawer that had 2 dead bugs on the towel. -There were crumbs of dried food on the floor with dirt. Observation of the kitchen cabinets on 08/09/23 from 8:00am to 8:08am revealed: -There was a dead roach under the cabinet below the kitchen sink with roach excrement and mice droppings. -There was a dark brown substance covering the two shelves in a cabinet under the kitchen counter to the right of the stove with roach excrement, mouse droppings and debris.	C 078		

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C 078	Continued From page 12 -The canned food items and bottles in the two shelves in the cabinet under the kitchen counter to the right of the stove had brown stains and roach casings stuck to them. Observation of a four tiered shelf in the kitchen on 08/09/23 at 7:43am revealed: -There was a 25.3 ounce container multipurpose cleaner beside a box of cookies that was opened on the top shelf, the multipurpose cleaner had a warning to keep out of reach of children, harmful if swallowed, can cause moderate eye irritation, avoid contact with eyes and clothing, -There was a 17.5 ounce aerosol container of roach, ant, and spider spray on the second shelf with a warning to keep out of reach of children, store in a well-ventilated place, if breathing difficulties, remove victim to fresh air and keep at rest in a position comfortable for breathing, get medical advice/attention if a person felt unwell, in case of contact, wash skin with plenty of water, symptoms of exposure may include, irritation of eyes and nose, cough and/or shortness of breath, avoid breathing mist, avoid contact with skin and eyes, do not swallow, when using do not eat, drink or smoke. -There was a 16.5 ounce aerosol container for treatment of bedbugs, fleas, and tick killer on the second shelf with a warning the product was an extremely flammable aerosol, it may cause an allergic skin reaction, it may be fatal if swallowed and enters airways, keep away from heat, avoid breathing fumes, gas, mist, vapors, or spray, if on skin wash with plenty of water If skin irritation or rash occurs, and if swallowed immediately call a poison center or physician. Observation of the enclosed sunroom on 08/09/23 at 7:51am revealed: -There were five dead flies in the windowsill that	C 078		

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faced the front porch ramp.
-There were eleven dead flies in the windowsill that faced the side yard, behind a couch.
-There was a table in front of two windows with a 20 ounce aerosol window cleaner with a warning keep out of reach of children and avoid contact with skin, eyes and clothing, a 12 ounce tub of hair conditioner with a warning that exposure to diethylene glycol monobutyl ether can result in skin irritation and contact dermatitis, pre-existing disorders of the skin, eyes, and respiratory tract may be exacerbated by exposure to diethylene glycol monobutyl ether, and a one quart container of motor oil with a warning to keep out of reach of children, avoid contact with eyes. avoid prolonged contact with skin, avoid breathing oil mists, use with adequate ventilation, wash thoroughly with soap and water after handling.
-There was a bookshelf with three shelves.
-The top shelf of the bookshelf had a 12 ounce bottle of liquid concentrated cleaning liquid on the top shelf with a warning to keep out of reach of children, hazardous to humans, corrosive and harmful if swallowed, causes irreversible eye and skin burns, wear protective eyewear and protective gloves, avoid prolonged breathing of vapor or mist, if swallowed or product gets on skin call a poison control center or physician for medical advice.
-The second shelf of the bookshelf had a one quart ready to use, intermediate level, one step cleaner and disinfectant on the second shelf with a warning to wash hands and any exposed skin after handling, if skin or eye contact get medical attention, if inhalation remove victim to fresh air and keep at a rest position for comfortable breathing, call a poison control center or physician if you feel unwell.
-The third shelf of the bookshelf had two one quart bottles on the third shelf of ready to use,

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C 078	Continued From page 14 intermediate level, one step cleaner and disinfectant on the second shelf with a warning to wash hands and any exposed skin after handling, if skin or eye contact get medical attention, if inhalation remove victim to fresh air and keep at a rest position for comfortable breathing, call a poison control center or physician if you feel unwell. Observation of the dining room on 08/09/23 at 7:47am revealed: -There was an uncovered 13 ounce container of petroleum jelly on the buffet in the dining room with a warning to keep out of reach of children, avoid getting product in eyes, if swallowed get medical help or contact a poison control center immediately. -There was a 12 ounce tub of hair conditioner on the dresser beside the window with an air-conditioning unit with a warning that exposure to diethylene glycol monobutyl ether can result in skin irritation and contact dermatitis, pre-existing disorders of the skin, eyes, and respiratory tract may be exacerbated by exposure to diethylene glycol monobutyl ether. -There were linens draped over the buffet and dresser that had spots of roach excrement. -There was a 12 ounce unopened box of cereal, two cereal bowls and one plastic mixing bowl on top of the china cabinet. Observation of a resident's bedroom on 08/09/23 at 8:32am revealed: -There were three bed bugs crawling on the top sheet of his bed. There were numerous blood stains from bed bug excrement on his top sheet, fitted sheet and pillowcase. -There was roach excrement at the top of the curtains.	C 078		

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C 078	Continued From page 15 -There was a 17.5 ounce aerosol spray container of bed bug killer on the nightstand beside his bed with a warning the spray was harmful if inhaled, could cause an allergic reaction of the skin, avoid breathing mist or spray, use only outdoors or in a well ventilated area, wear protective gloves, if inhaled remove person to fresh air and keep comfortable for breathing, and call a poison center or physician if a person felt unwell. Interview with a resident on 08/09/23 at 9:30am revealed: -The MA/Administrator sprayed his bed with spray whenever she saw a bedbug on his bed. -He observed bedbugs on his crawling on his bed and his bedroom wall most days and nights. -He used the spray a few times a week on his sheets and pillowcase. -The MA/Administrator took his mattress outside three times a month to spray it with bedbug spray and let it sit in the sun to help get rid of the bedbugs and roaches. -The MA/Administrator told him that the sun on his mattress helped bring the bedbugs and roaches out of his mattress. -The bedbugs had bitten him every night for approximately two months. -He had observed roaches in his bedroom, the kitchen, dining room, bathroom and living room. -When he saw a roach on the floor during the daytime, he would step on them to kill it. -He was used to stepping on roaches in the home to kill them because he saw them so frequently. -He had told the MA/Administrator at least once a week for the past two months that there were bedbugs and roaches in the facility, that he was having trouble sleeping due to the bugs and he was itching. Observation of a second resident's bedroom on	C 078		

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C 078	Continued From page 16 08/09/23 at 8:32am revealed: -There were three live bedbugs crawling on the top sheet. -There were dead roaches in two windowsills. Interview with a second resident on 08/09/23 at 2:55pm revealed: -She observed bedbugs on her bed a few times a week. -She had noticed more bedbugs on her comforter, sheets and pillow the past three weeks. Interview with a third resident on 08/09/23 at 9:45am revealed: -He had been at the home for about one and half months. -He stepped on roaches on his bedroom floor when he saw them to kill them. -He reported the roaches to the MA/Administrator a few days ago. -An exterminator came to spray the home two days ago. Interview with a fourth resident on 08/10/23 at 2:40pm revealed: -She saw roaches all over the home every day. -Since the exterminator came to spray the home last week and she noticed there was less roach activity. -When she saw a bedbug on her bed, she would use her hand to knock them to the floor and try to kill them. -She had problems with itching on her arms, legs and back for about three months. -She could not remember if she had informed the MA/Administrator about her problems with itching. Interview with a fifth resident at the facility on 08/09/23 at 9:50am revealed:	C 078		

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C 078	Continued From page 17 -He observed roaches in his bedroom, the resident bathroom, the kitchen, and the dining room daily. -An exterminator had sprayed the facility a few days ago but he had not noticed a change in the roach activity. Telephone interview with a local exterminator on 08/10/23 at 12:29pm revealed: -He had treated the home for bedbug activity during May 2022. -During his treatment of the home in May 2022 he observed bedbug activity in multiple rooms. -He observed bedbugs crawling on the living room couch, on resident beds, on curtains in the home, the walls of the home and the ceilings of the home. -There was a bedbug infestation in the home when he treated it in May 2022. -Bedbugs multiplied rapidly and within 30 to 60 days a few bedbugs could cause a full-blown infestation. -He instructed the MA/Administrator to check each resident when they returned to the home, check their clothing, bags and the resident's hair. -He explained to the MA/Administrator that bedbugs cling to any type of fabric and that it was important to remain proactive to take steps to decrease the bedbug activity in the home. -He advised the MA/Administrator to remove all linens and clothing from the home and dry on high heat for at least one cycle to kill the bedbugs. -He thought he treated the home 2 more times after his first treatment in May 2022 but was unable to remember the dates. -Bedbug activity in the home could affect the residents mentally due to the stress and anxiety of seeing bedbugs in the home and itching after being bit at night while they slept.	C 078		

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C 078	Continued From page 18 Telephone interview with the facility's contracted pest control company on 08/11/23 at 10:17am revealed: -She provided the first treatment of the home for roaches and rodents on 08/04/23. -There was an infestation of roaches and rodents. -She treated the facility for German roaches and rodents. -German cock roaches were the worse because they multiplied rapidly. -One German roach egg could produce up to twenty roaches in 30 days. -When she saw two roaches it meant there were at least 40 additional roaches in the same area. -When roaches were observed with lights on the infestation was considered very bad because roaches were nocturnal and usually only came out at night. -When she opened drawers in the kitchen numerous roaches crawled to the top of the drawer. -When she placed bait under the cabinets in the kitchen, she observed live roaches falling to the bottom of the cabinets. -The infestation in the kitchen caused health concerns for the residents and anyone eating at the home due to her observation of numerous live roaches, their casings, and their excrement. -Due to the roach and rodent infestation in the home food should not be prepared in the kitchen to prevent residents from becoming sick. -Roaches carried bacteria and viruses such as E. coli (Escherichia Cola is a bacteria know to cause illnesses including urinary tract infections, pneumonia, and infection of the membranes around the brain and spinal cord), Salmonella (salmonella is a bacteria that can result in diarrhea, fever and stomach cramps), and Polio which is a disabling and life threatening illness.	C 078		

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C 078	Continued From page 19 -The MA/Administrator showed her several areas of mouse droppings and mouse nesting areas in the home. -She observed live bedbugs and bedbug excrement in each residents' rooms and the MA/Administrators bedroom. -She informed the MA/Administrator that she would need to call to schedule a time to treat the home for bedbugs as of 08/11/23 she had not received a call from the MA/Administrator to treat the home for bedbugs. -She was scheduled to return in September 2023 to complete her second treatment for cock roaches and rodents. Telephone interview with a resident's primary care provider (PCP) on 08/09/23 at 11:50am revealed: -Bedbug bites left untreated could cause severe skin infections from a resident itching excessively. -A secondary skin infection from excessive scratching of bedbugs could cause a bacterial skin infection that if left untreated could become septic. -Roaches, roach casings and roach excrement around food could cause methicillin-resistant staphylococcus aureus (MRSA), (MRSA is a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). -Roaches, roach casings and roach excrement around food could cause vancomycin-resistant enterococci (VRE) and spread from person to person easily, (VRE is a type of bacteria that is resistant to many antibiotics, including vancomycin). -Roaches, roach casings and roach excrement around food could cause Escherichia coli (E. coli is a severe form of bacteria that can severe food poisoning) and if left untreated could become	C 078		

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C 078	Continued From page 20	C 078		

septic and could be fatal.
-Roaches, roach casings and roach excrement around food could cause Salmonella (Salmonella is an infection that can cause diarrhea, fever, and stomach pains.)

Interview with the MA/Administrator on 08/09/23 at 10:11am revealed:
-An exterminator came to treat the facility for roaches and rodents on 08/04/23.
-She did not think that an exterminator had been to the facility since COVID-19.
-She contacted an exterminator because she started seeing more and more roaches and mouse droppings.

A second interview with the MA/Administrator on 08/09/23 at 2:15pm revealed:
-She noticed increased roach and bedbug activity in July 2023.
-She observed roaches crawling on walls in the dining room, resident rooms, and the kitchen.
-She observed roaches crawling on the floor throughout the home.
-When she saw a roach on the floor, she would "stomp" them with her foot to kill them.
-She had attempted to contact several exterminators since July 2023 but had not been able to get any of them to return her call.
-She called an exterminator company again two weeks ago and an exterminator came on 08/04/23 to treat the home for roaches and rodents.
-She observed what she thought was a bedbug on the wall of the bedroom where two female residents resided several months ago.
-She removed the bug from the wall, placed the bug in a plastic bag, showed it to a friend and asked what type of bug it was.
-She then took the bug in the plastic bag to a

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local hardware store to help identify the bug.
-The local hardware store provided her with recommendations on how to treat bedbugs.
-She and the residents had to leave the home at 9:00am and returned at 1:00pm when she set off foggers in the home to treat the bedbugs.
-She had last seen a bedbug in the female resident's room on top of a wig mannequin two weeks ago.
-She sprayed areas of the home with bedbug and roach spray to help kill the bedbugs and roaches.
-She checked resident beds for bedbugs every day, which included checking the comforter, sheets, mattress, and pillow.
-She pulled the corners of the sheet back to check the crevices of the mattress and had not seen any bedbugs in a month.
-She paid a local exterminator company she thought in May 2022 and the home was treated by an exterminator in May 2022 for bedbugs.
-The local exterminator had instructed her to treat all linens and clothing by removing them in bags from the home and drying them in a dryer to kill the bedbugs with heat.
-She and the residents took all the clothing and bedlinens in the home to the laundromat to dry with heat a few days after the exterminator left the facility.

A third interview with the MA/Administrator on 08/11/23 at 4:30pm revealed:
-She sprayed the house daily with roach spray and bedbug spray to help kill the roaches and bedbugs in the home.
-She purchased 15 cans of roach and bedbug spray last week to use at the home.
-She changed each residents bedlinens daily, washed the bedlinens and put the bedlinens on the clothesline to dry.
-She had three dryers on the property but only

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C 078	Continued From page 22 one was working. -She only took bedlinens and clothes to the laundromat in the winter months because she did not use the clothesline to dry clothes in the winter months. -She cleaned the facility at least once a day and had someone hired that came once every two weeks to deep clean the facility. -She was not aware that chemicals needed to be stored in a safe location, she had always kept them around the facility so she could use them when needed. Request for the facility's policy on storage of chemicals on 08/11/23 revealed no policy or procedure on the storage of chemicals was provided prior to exit. _____ The facility failed to ensure that 6 of 6 residents were provided with a clean and safe environment protected from hazards including an active infestation of roaches, bedbugs, and mice identified by an exterminator's recent assessment and treatment, and chemicals improperly stored. The facility's failure to keep a sanitary and safe environment resulted in residents exposed to roaches and bedbugs and chemical hazards causing a substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/09/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2023.	C 078		

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C 100	Continued From page 23	C 100		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that fire evacuation plans (fire drills) included a description of the fire drill's details and what staff were involved in the fire drill. The findings are: Observation of the facility on 08/09/23 at 7:30am revealed: -There were two entrances to the facility. -There was a small front porch with steps and a wheelchair ramp that led to the front yard. -There was small covered back porch with a wheelchair ramp that led to the side yard. Interview with the medication aide (MA)/Administrator on 08/09/23 at 7:15am revealed: -The facility's current census was six residents. -All six residents were independent, ambulated	C 100		

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C 100	Continued From page 24 independently and were alert and oriented. Review of the facility's fire drill rehearsal records revealed: -There was a fire drill conducted on 03/12/23, at 3:00pm that took six minutes to complete. -There was no documentation of how many residents participated in the drill, a description of the fire drill or staff that participated. -There was a fire drill conducted on 03/31/23, at 3:30pm that took four and a half minutes to complete. -There was no documentation of how many residents participated in the drill, a description of the fire drill or staff that participated. -There was a fire drill conducted on 04/0523, at 4:15pm that took five minutes to complete. -There was no documentation of how many residents participated in the drill, a description of the fire drill or staff that participated. -There was a fire drill conducted on 04/19/23, at 5:20pm that took five minutes to complete. -There was no documentation of how many residents participated in the drill, a description of the fire drill or staff that participated. Interview with a resident on 08/11/23 at 3:09pm revealed: -The facility has fire drills sometimes but "not too often". -When the facility had a fire drill the alarm sounded and he went outside and when the alarm stopped, he went back inside. Interview with a second resident on 08/11/23 at 3:22pm revealed: -The facility had fire drills, but he was not sure how often. -When there was a fire drill an alarm sounded. -When the alarm sounded, he tried to "cut it off".	C 100		

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C 100	Continued From page 25 -When the alarm sounded it meant he was supposed to go outside. Interview with the Administrator on 08/10/23 at 4:40pm revealed: -She had not thought about the possibility that she may not be able to assist her elderly family member out of the home if she were injured. -She had never documented a description of the fire drills or individuals who participated in the fire drills.	C 100		
C 186	10A NCAC 13G .0601 (b)(1) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used: (1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home;	C 186		

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

Based on observations, interviews, and record reviews the facility failed to ensure the Administrator was responsible for the total operation of the home and that at no time a resident was left alone.

The findings are:

Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 6 residents, up to three residents could be non-ambulatory.

Interview with the medication aide (MA)/Administrator on 08/09/23 at 7:15am:
-There was a current census of 6 residents at the facility.
-The residents ambulated independently and were alert and oriented.
-She was responsible for the total operations of the facility.
-She was on-site at the facility every day, if she ever had to leave a family member came to stay with the residents.

Interview with a resident on 08/10/23 at 2:45pm revealed:
-The MA/Administrators elderly family member lived at the home in a back bedroom.
-When the MA/Administrator had to leave the home to run errands, or when she was "gone a long time," she asked her to sit with her elderly family member.

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WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 186	Continued From page 27 Interview with the second resident on 08/10/23 at 3:36pm revealed when the MA/Administrator had to leave the home for a few hours, she asked her to sit with her elderly family member. Interview with the third resident on 08/10/23 at 3:47pm revealed: -The MA/Administrator asked him every week to go with her to take the trash to the local dump and he would unload the trash from the truck. -Some of the resident's stayed at the home by themselves because everyone could not ride in the truck. -When the resident's stayed at home they usually sat outside, and one resident liked to stay in his bedroom. Interview with the fourth resident on 08/10/23 at 3:40pm revealed: -There were two female residents that stayed at the facility. -When the MA/Administrator had to leave the facility, she asked one of the female residents to stay with her elderly family member in a back bedroom until she returned home. -The residents were at the facility by themselves, but if they needed help, they could go to the MA/Administrators family members home next door. Interview with the MA/Administrator on 08/11/23 at 4:30pm revealed: -She never left residents at the home alone. -When she had to go somewhere she took the residents with her on a van or had her family member from next door come sit with the residents. -When she took the trash to the dump with a few residents, her family member came from next	C 186		

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C 186	Continued From page 28 door to watch the residents. -She and her family member next door worked together to ensure that the residents were never left alone at the home. _____ __ The Administrator failed to ensure residents were not left at the home alone while she ran errands or took some residents to help empty trash at the dump. This failure to ensure a staff person was at the facility at all times and that at no time were any residents were left alone was detrimental to the health, safety, and welfare of the 6 residents residing at the facility and constitutes a Type B Violation. _____ _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2023.	C 186		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service	C 202		

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C 202	Continued From page 29 Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 residents sampled (#2) had completed tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #2's current FL-2 dated 03/08/23 revealed diagnoses included Alzheimer's dementia, hypertension, seasonal allergies, and gastroesophageal reflux disease (GERD). Review of Resident #2's Resident Register revealed he was admitted to the facility from his residence on 05/01/22. Review of Resident #2's facility record on 08/09/23 revealed: -There was a tuberculosis (TB) test administered on 04/25/22 and read as 0 millimeters (mm) on 04/27/22. -There was no second TB test. Interview with the Administrator on 08/11/23 at 4:44pm revealed: -She knew residents needed 2 TB tests when they were admitted to the facility. -She normally took residents to a local health clinic to receive the TB test. -She did not know why Resident #2 did not receive a second TB test.	C 202		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service	C 257		

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C 257	Continued From page 30 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record review and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to observations of expired, molded, unlabeled and undated foods; improper storage of food items in the refrigerator and roaches; roach excrement and mouse droppings in the refrigerator, kitchen cabinets, counters, and the storage of cleaning agents and insecticides with food products. The findings are: Review of an Environmental Health report dated 08/11/23 for the facility revealed: -There were 18 total demerits, and the facility received a provisional status. -There were 4 demerits for an excessive amount	C 257		

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C 257	Continued From page 31 of live and dead roaches in the kitchen, evidence of mice droppings in the kitchen cabinets. -There were 4 demerits for substances containing poisonous material not used for cleaning or polishing eating or cooking utensils, the stove had a drawer that did not work properly and was not cleaned regularly, the refrigerator needed to be deep cleaned, chemicals were stored with food products, and utensils were not stored and considered clean, utensils were in a dirty drawer and were not clean to sight. -There were 2 demerits for improper storage of chemicals, cleaning supplies and pesticides; they were stored with food products. -There was a notation that food in freezer and refrigerator should be covered and protected, and open food should not be reserved when cooked for an individual or prepared for an individual. Observations of the kitchen on 08/09/23 from 7:30am to 10:27am revealed: -There was one dead roach under the corner of a cutting board on the kitchen counter to the right of the stove. -Two small roaches that crawled on the dining room table. -There was roach excrement on linens that covered the buffet and dresser in the dining room. Observation of the kitchen counter to the left of the stove on 08/09/23 at 7:45am revealed: -There was an adult roach crawling from the middle of the counter to the front of the counter beside a calendar book to the left of the stove. -There was an uncovered clear glass bowl of strawberry preserves in front of an uncovered 19 ounce aerosol can of disinfectant spray. -The bowl of strawberry preserves was also in front of a box of pesticides that killed roaches, the box contained four 1.25 ounce bait syringes.	C 257		

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C 257	Continued From page 32 -There was a 12 ounce barbeque sauce bottle beside the box of bait syringes that did not have a lid. -There was one two ounce roach fogger beside a quarter loaf of bread that was not secured. -There was a wig on top of an insulated bag and papers in the corner of the kitchen counter below the pantry doors above it. Observation of the stove in the kitchen on 08/09/23 at 7:52am revealed: -There was an uncovered stainless steel bowl of grease, an uncovered hot sauce bottle and an unsecured bag of grits on the stove ledge. -There was a glass bowl with strawberry preserves and a spoon that was uncovered beside a disinfectant aerosol spray with no lid that was previously observed on the kitchen counter to the left of the stove. -There was a 12 ounce container of mustard that did not have a lid at the center of the stove. -There was a blue plastic glove beside the container of mustard on the stove. -There were 2 cooking skillets on the second rack in the oven. -There were 2 cooking skillets on the third rack in the oven. -The oven drawer at the bottom of the oven was not working properly and jutted out on the right side. Observation of the kitchen counter to the right to the stove on 08/09/23 7:55am revealed: -There was one dead roach under a cutting board. -There was one aerosol container of roach, ant, and spider spray beside three coffee mugs. Observation of the kitchen counter to the right of the sink on 08/09/23 at 7:55am revealed:	C 257		

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C 257	Continued From page 33 -There was an opened loaf of bread sitting on top of coffee grounds. -There was one aerosol spray container of roach spray behind the loaf of bread. Observation of the kitchen cabinets on 08/09/23 from 8:00am to 8:08am revealed: -There was an unopened 3.25 ounce container with gelatin turned upside down on the bottom shelf of the cabinet to the left of the refrigerator with a dead adult roach on it. -There was roach excrement and mouse droppings in three cabinets with plates, bowls, and glasses. -There was roach excrement and mouse droppings on canned food items and on the shelving in two cabinets below the kitchen counter to the left of the refrigerator. -There was roach excrement and mouse droppings on the shelving of two shelves in a cabinet above the kitchen counter to the left of the refrigerator. -The canned food items and bottles in the two shelves in the cabinet under the kitchen counter to the right of the stove had brown stains and roach casings stuck to them. -There was roach excrement, dead roaches, and mouse droppings in the silverware drawer, a drawer to the left of the refrigerator and a drawer to the left of the stove. -There was a 12 ounce jar of peanut butter with a best by date on the lid of 12/29/20. -There was a clear package of shredded wheat cereal that was tied with a rubber band that was undated. -There was an opened plastic bag of sugar cookie mix with roach excrement beside the plastic bag. -There was evidence of roach excrement on the shelf lining.	C 257		

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C 257	Continued From page 34 -There was a 14.5 ounce aerosol can of heavy duty oven spray without a lid beside a box of individually packaged grits on the bottom cabinet to the left of the stove. Observation of the refrigerator on 08/09/23 at 8:15am revealed: -There was evidence of roach excrement on the top shelf of the refrigerator. -There was a half gallon of milk, a half gallon of water, and a 32 ounce bottle of apple cider vinegar on the top refrigerator shelf all without a lid. -There was an open package of 8 sausage links on the second shelf with a package of 8 hamburger buns leaning on the back of the sausage link packaging. -There was a 30 ounce jar of mayonnaise laid down on the on the second shelf with the lid removed from the jar and sitting beside the jar of mayonnaise. -There was an uncovered 12 ounce glass jar of grape jelly that was ¾ full with white, fuzzy substance with small green circles of mold on the second shelf. -There was a clear plastic container with green beans on the second shelf that was not covered. -There was an opened plastic bag of frozen fish sticks on the third shelf with a use by date of 01/14/21. -There was an opened package with two chicken breasts stuffed with ham and cheese on the third shelf with a sell by date of 07/16/23, there was a cut opening down the middle of the package between the two chicken breasts exposing the food. -The first drawer at the bottom of the refrigerator had roach excrement scattered in the drawer and a dried corn on the cobb at the back of the drawer.	C 257		

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C 257	Continued From page 35 Observation of the side storage door of the refrigerator on 08/090/23 at 8:09am revealed: -In the upper compartment of the refrigerator door there was an unwrapped stick of butter sitting directly on the refrigerator shelf along with 11 individual wrapped slices of cheese. -There were 7 small dead roaches beside an unwrapped stick of butter sitting directly on the refrigerator shelf along with 11 individual wrapped slices of cheese. -The top part of the refrigerator door seal had several small dead roaches. -There was an adult dead roach on the bottom shelf of the refrigerator door and roach excrement. -There was roach excrement on refrigerator shelves and side shelves of the door. -There were two sealed packages of bacon on the second side storage shelf sitting on top of an unopened sleeve of crackers. -There was roach excrement on the third side storage shelf with one egg with a cracked shell sitting on the roach excrement. -There was a discolored lemon with brown marking on the fourth side storage shelf. -There were two small dead roaches beside the discolored lemon. -There was an 8 ounce bottle of salad dressing that was half empty with an expiration date of 09/14/21 on the fourth side storage shelf of the refrigerator. Observation of the kitchen on 08/10/23 at 4:41pm revealed there was an adult roach that crawled on the counter to the left of the refrigerator, the state surveyor informed the medication aide (MA)/Administrator, and she sprayed the roach on the counter to attempt to kill it.	C 257		

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C 257	Continued From page 36 Interview with a resident on 08/09/23 at 9:30am revealed: -He had observed roaches in the kitchen and dining room. -When he saw a roach on the floor during the daytime, he would step on them to kill it. -He was used to stepping on roaches in the home to kill them because he saw them so frequently. Interview with a second resident on 08/10/23 at 2:40pm revealed she saw roaches all over the home every day. Interview with a third resident at the facility on 08/09/23 at 9:50am revealed: -He observed roaches in the kitchen and the dining room daily. -He killed a roach with a napkin a few days ago when he was eating breakfast at the dining room table because it was crawling toward his plate. -An exterminator had sprayed the facility a few days ago but he had not noticed a change in the roach activity. Telephone interview with the facility's contracted pest control company on 08/11/23 at 10:17am revealed: -She provided the first treatment of the home for roaches and rodents on 08/04/23. -There was an infestation of roaches and rodents. -When she opened drawers in the kitchen numerous roaches crawled to the top of the drawer. -When she placed bait under the cabinets in the kitchen, she observed live roaches falling to the bottom of the cabinets. -The infestation in the kitchen caused health concerns for the residents and anyone eating at the home due to her observation of numerous live roaches, their casings, and their excrement.	C 257		

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C 257	Continued From page 37 -Due to the roach and rodent infestation in the home, food should not be prepared in the kitchen to prevent residents from becoming sick. -Roaches carried bacteria and viruses such as E. coli, salmonella, and could also cause Polio. -The MA/Administrator showed her several areas of mouse droppings and mouse nesting areas in the home. -She was scheduled to return in September 2023 to complete her second treatment for cock roaches and rodents. Telephone interview with a resident's primary care provider (PCP) on 08/09/23 at 11:50am revealed: -Roaches, roach casings and roach excrement around food could cause Methicillin-resistant staphylococcus aureus (MRSA), (MRSA is a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). -Roaches, roach casings and roach excrement around food could cause Vancomycin-resistant enterocolitis (VRE) and spread from person to person easily, (VRE is a type of bacteria that is resistant to many antibiotics, including Vancomycin). -Roaches, roach casings and roach excrement around food could cause Escherichia coli (E. coli is a severe form of bacteria that can severe food poisoning) and if left untreated could become septic and could be fatal. -Roaches, roach casings and roach excrement around food could cause Salmonella (Salmonella is an infection that can cause diarrhea, fever, and stomach pains.) Interview with the MA/Administrator on 08/09/23 at 10:11am revealed: -An exterminator came to treat the facility for roaches and rodents on 08/04/23.	C 257		

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C 257	Continued From page 38 -She did not think that an exterminator had been to the facility since COVID-19. -She contacted an exterminator because she started seeing more and more roaches and mouse droppings. A second interview with the MA/Administrator on 08/09/23 at 2:15pm revealed: -She had observed roaches crawling on walls in the dining room and the kitchen. -She observed roaches crawling on the floor throughout the home. -When she saw a roach on the floor, she would "stomp" them with her foot to kill them. -She had attempted to contact several exterminators since July 2023 but had not been able to get any of them to return her call. -She called an exterminator company again two weeks ago and an exterminator came on 08/04/23 to treat the home for roaches and rodents. A third interview with the MA/Administrator on 08/11/23 at 4:30pm revealed: -She sprayed the house daily with roach spray to help kill the roaches in the home. -She cleaned the facility at least once a day and had someone hired that came once every two weeks to deep clean the facility. -She was not aware that chemicals could not be kept on the kitchen counters and kitchen cabinets. _____ The facility failed to ensure all residents were protected from illness from foods exposed to live roaches, dead roaches, mouse droppings, cleaning agents and insecticides. Food was uncovered throughout the kitchen and refrigerator beside insecticides and dead roaches were found inside the refrigerator under an opened stick of	C 257		

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C 257	Continued From page 39 butter. The facility's failure to ensure food was stored and prepared to prevent contamination from infectious forms of bacteria placed the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/09/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2023.	C 257		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Review of the facility's census revealed there were 6 residents residing at the facility. Observations of the residents on 08/09/23 from 8:00am to 10:28am revealed: -No group activities were offered to the residents. -At 8:00am one resident was in his bedroom sleeping. -At 8:05am three residents were in the front yard	C 288		

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C 288	Continued From page 40	C 288		

sitting in chairs.
-There were no activities offered by the medication aide (MA)/Administrator.
-At 9:30am one resident was in his bedroom sleeping.
-At 9:32am three residents were in the front yard sitting in chairs.
-There were no activities offered by the MA/Administrator.
-At 10:27am one resident was in his bedroom sleeping.
-At 10:28am three residents were in the front yard sitting in chairs.
-There were no activities offered by the MA/Administrator.

Observation of the facility activity calendar revealed:
-A devotional time was scheduled for 08/09/23 at 9:00am.
-Stretching exercises were scheduled for 08/09/23 at 10:30am.
-The MA/Administrator did not offer devotional time or stretching exercises.

Observations of the residents on 08/10/23 from 10:50am to 11:10am revealed:
-No group activities were offered to the residents.
-One resident was in his bedroom sleeping.
-Three residents were in the front yard sitting in chairs.
-There were no activities offered by the MA/Administrator.

Observation of the facility calendar revealed stretching exercises were scheduled for 08/10/23 at 10:30am; stretching exercised were not offered by the MA/Administrator.

Observations of the residents on 08/10/23 from

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C 288	Continued From page 41 3:36pm to 3:50pm revealed: -No group activities were offered to the residents. -One resident was in his bedroom sleeping. -Five residents were in the front yard sitting in chairs. -There were no activities offered by the MA/Administrator. Observation of the facility calendar revealed a game was to be played with residents at 3:00pm; residents were not offered an activity by the MA/Administrator. Observations of the residents on 08/11/23 from 8:30am to 9:15am revealed: -No group activities were offered to the residents. -One resident was in his bedroom sleeping. -Two residents were in the front yard sitting in chairs. -There were no activities offered by the MA/Administrator. Observation of the facility calendar revealed devotional time was scheduled on 08/11/23 at 9:00am; the MA/Administrator did not offer a devotional activity to residents. Observation of the facility on 08/10/23 at 4:40pm revealed there was one board game in its box on the floor in the dining room beside the china cabinet with several towels in front of the board game. Observation of the back porch on 08/11/23 at 10:56am revealed there was a board game in its box on top of a two shelved wooden linen closet with linens stored in it. Interview with a resident on 08/10/23 at 3:47pm revealed:	C 288		

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C 288	Continued From page 42 -When he was not asked to help with chores by the medication aide (MA)/Administrator, he sat outside with the other residents and watched cars go by. -Residents did not have any board games, puzzles, or cards to play with at the home. -Residents went to church once or twice a month on Sunday's but they never had visitors come to the home to provide music or provide Bible study. -He had never seen an activity calendar at the home. -He would like to play bingo, board games and have singing activities. Interview with a second resident on 08/10/23 a 3:51pm revealed: -He used to attend a day program where he enjoyed participating in activities such as board games and bingo. -Residents at the home did not play bingo, board games, or cards. -He and other residents usually spent their days outside watching cars pass by the home. Interview with the MA/Administrator on 08/11/23 at 4:30pm revealed: -She was responsible for providing all activities to the residents. -Two of the female residents went to a day program Monday through Friday. -The activity calendar was not posted because it had fallen from the dining room wall onto the buffet in the dining room. -She did not realize that an activity calendar needed to be posted where the residents could see it. -Residents played ball at times, tossed a ball outside and completed word search puzzles. -She only had two board games at the home for residents and thought they enjoyed sitting outside	C 288		

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C 288	Continued From page 43 and watching cars for their activities each day. -She did not attempt to provide activities she had listed on the activity calendar such as stretching exercises, devotional time, or games because the residents enjoyed resting, watching television, or sitting outside.	C 288		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure residents 6 of 6 residents were treated with dignity and respect and free from exploitation related to residents being asked to do chores and being reprimanded if not completed, providing care to an elderly family member of the medication aide (MA)/Administrator and having an infestation of bed bugs and roaches which caused residents to suffer bites and itching. The findings are: 1. Observation of a resident on 08/09/23 at 4:20pm revealed: -She was standing at the entryway of the kitchen listening to the medication aide (MA)/Administrator and her family member explain how to clean out the cabinets below the kitchen counters. -The resident laughed and told the	C 311		

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C 311	Continued From page 44 MA/Administrator, "if you don't work, you don't eat." Interview with a resident on 08/09/23 at 4:25pm revealed: -She helped the MA/Administrator with chores around the home when she asked her to help. -She usually helped with chores such as cleaning and raking the yard a few times a week when the MA/Administrator asked her to help. -When she completed chores for the MA/Administrator she received a popsicle as a reward. Observation of the MA/Administrator on 08/09/23 at 4:27pm revealed: -She came to the front porch and called for a resident to come inside the home and help her. -The resident was outside speaking with the state surveyor. Interview with the MA/Administrator on 08/09/23 at 4:37pm revealed: -She planned to reward the resident that helped clean the kitchen cabinets $20. -The residents did not help her or work for her for "nothing," she paid them or rewarded them for helping her. Interview with a resident on 08/10/23 at 2:45pm revealed: -The MA/Administrator called her from outside to come inside yesterday afternoon to help clean out the kitchen cabinets under the counters. -She sat in a chair to remove items from the cabinet under the kitchen counter, because she could not physically sit on the floor. -She did not complete the project that the MA/Administrator assigned her yesterday afternoon because her back became sore from	C 311		

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bending so many times to reach the items in the cabinet.
-She told the MA/Administrator she needed to take a break because her back was tired and went outside to rest.
-The MA/Administrator paid her $6.00 for the help she provided yesterday.
-She did not get paid the $20.00 the MA/Administrator told her she planned to pay her for helping because she stopped and went outside to rest.
-The MA/Administrator called her name and said, "you stopped and went outside so you're only getting $6.00."
-She was used to helping the MA/Administrator with different chores every day.
-When the MA/Administrator or her family member returned to the home with food from a food pantry they would blow the horn when they entered the driveway.
-She and other residents were expected to come outside when the MA/Administrator or her family member blew the car horn to help unload the food items.
-She and other residents were expected to help unload food items from the vehicle, sort the food, and organize the food in the storage unit beside the home.
-The residents that helped received a reward such as a popsicle or ice cream, and if a resident did not help they did not receive a reward.
-When she returned home from her day program during the week, the MA/Administrator asked her to help with various chores.
-She helped the MA/Administrator by raking leaves in the yard, sweeping, and mopping the floors in the home, and hanging laundry on the clothesline.
-The MA/Administrator had asked her several times to scrub the resident's bathroom floor which

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she did because she would usually get a reward of a popsicle or ice cream.
-The MA/Administrator asked her to help take trash to the local dump most weeks, she and other residents that went unloaded the trash from the truck.
-When the MA/Administrator saw residents helping with chores she asked them to help with they were usually rewarded with ice cream or popsicles.
-The MA/Administrator would not provide rewards of ice cream or popsicles when a resident did not help with a chore.
-The MA/Administrators elderly family member lived at the home in a back bedroom.
-When the MA/Administrator had to leave the home to run errands, or when she was "gone a long time," she asked one or both female residents to sit with her elderly family member.
-When she sat with the MA/Administrators elderly family member in her bedroom, she and another female resident would help change her adult incontinence brief and help reposition her in the bed.
-She helped the MA/Administrators elderly family member transfer from the bed to the bedside commode, put socks on her and sit with her to be sure she did not need anything.
-When she was at her day program during the week the MA/Administrator had a family member, or the cleaning lady help her bathe her mother and comb her hair.
-She had recently observed a resident who lived at the facility with her clean the gutters of the gutters.
-She did not observe any staff standing at the ladder when he went up the ladder and came back down.
-She had observed the same resident cut grass with a push mower at the home while the

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C 311	Continued From page 47 MA/Administrator used a riding lawn mower when they cut the grass together. Interview with the second resident on 08/10/23 at 3:36pm revealed: -The MA/Administrator asked her to help with various chores at the home weekly. -When the MA/Administrator told her to change the sheets, she took sheets off all the resident beds in the home and put new sheets on the resident beds. -Sometimes she received a popsicle for changing the bedlinens in the home. -It was her job to wipe the dining room table off every night after supper. -When she returned from her day program the MA/Administrator asked her to help with various chores such as cleaning the resident's community bathroom, dusting, and sweeping the home. -When the MA/Administrator had to leave the home for a few hours, she asked her to sit with her mother. -She was responsible for changing the MA/Administrator's elderly family members adult incontinence brief when needed. -She was not able to change the MA/Administrator's elderly family members adult incontinence brief independently, so she had to ask the second female resident that lived at the home to help change the adult incontinence brief. -Sometimes the MA/Administrator gave her a reward of a popsicle for completing chores. -The MA/Administrator had given her $5.00 or $6.00 a few times for helping with chores. -If a resident did not help with chores the MA/Administrator asked them to help with they did not receive a reward. Interview with the third resident on 08/10/23 at 3:40pm revealed:	C 311		

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C 311	Continued From page 48 -When the MA/Administrator asked residents at the home to help with chores they usually received a reward such as ice cream. -If residents did not help, they did not receive a reward. -When a resident did not help with a chore, the MA/Administrator would "fuss them out" for not helping; the MA/Administrator would tell a resident that did not help with a chore that they would not get a reward. -The MA/Administrator had made it clear to residents that if they do not help with what she asked them to do, they did not get a reward. -He was asked by the MA/Administrator each week to take the scrap food bucket from the kitchen to a wooded area behind the home to dump it. -The MA/Administrator also asked for his help with raking the yard a few times a month. Interview with the fourth resident on 08/10/23 at 3:47pm revealed: -The MA/Administrator asked him to help with various tasks around the home. -The MA/Administrator asked him every week to go with her to take the trash to the local dump and he would unload the trash from the truck. -The MA/Administrator asked for his help when she needed assistance lifting something heavy. -The MA/Administrator asked him to paint her bathroom door, he completed the job but did not remember if he received a reward. -The MA/Administrator asked him to clean the gutters on the home he lived in and the home next door where her family member lived. -He cleaned the gutters on both homes approximately four days ago. -He carried the ladder to both homes independently. -When he climbed up the ladder to both homes,	C 311		

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there were no staff or residents that "spotted" him.
-The MA/Administrator and her family member were not supervising him when he was on the roof of both homes cleaning the gutters.
-He "got a good treat" when he got off the ladder and the gutters were cleaned; the MA/Administrator's family member gave him ice cream and a "bag full of potato chips."
-When he helped the MA/Administrator with a job and "did something good for her," she usually gave him a candy bar.
-The MA/Administrator asked him three days ago to help cut the grass, he used a push mower to cut the grass and the MA/Administrator paid him $6.00.

Interview with the MA/Administrator on 08/11/23 at 4:15pm revealed:
-When the resident cleaned the gutters on both homes, she stood at the foot of the ladder to ensure his safety.
-The resident was never left unattended when he cleaned the gutters on both homes.

Interview with a fifth resident on 08/10/23 at 3:51pm revealed:
-The MA/Administrator asked him to help with different jobs around the home.
-He had helped the MA/Administrator when she asked him to pick up cans from the yard or rake the yard when he felt like helping.
-He knew he was supposed to "just do it" referring to the chore the MA/Administrator asked him to complete.
-Sometimes he did not physically feel like helping the MA/Administrator with chores and just wanted to enjoy his time sitting outside watching cars pass by the home.
-When he did not help the MA/Administrator he

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did not receive a reward or treat but residents who helped received ice cream for helping.
-The MA/Administrator often told him, "If you don't work, you don't get nothing."
-When he heard the MA/Administrator say, "if you don't work, you don't get nothing," he would usually walk to another area of the home or the yard because it hurt his feelings.
-He walked away because he did not want to say anything back to the MA/Administrator because he knew he would get in trouble.
-When the MA/Administrator asked him to help with a chore and he did not help, he got into trouble and the MA/Administrator would yell and fuss at him for not helping.
-When the MA/Administrator yelled and fussed at him it made his "heart sad," hurt his feelings and he felt that he was treated differently from the residents who helped her with chores.
-He knew that if he did not help with a chore the MA/Administrator asked him to help with he would not receive a treat or reward.

Interview with the MA/Administrator on 08/11/23 at 4:15pm revealed:
-She usually hired a friend to complete yardwork, general house repairs and clean the gutters.
-When she hired her friend to complete work, she paid him $12.00 per hour.
-She never asked residents to sit with her elderly family member, the two female residents always wanted to spend time with her elderly family member.
-She did not feel that she was wrong for giving residents a reward when she asked them to complete a chore.
-When a resident did not help complete a chore, she did not feel that they deserved a reward.
-She felt that she treated all residents the same.

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C 311	Continued From page 51 2. Observation of a resident's bedroom on 08/09/23 at 8:32am revealed: -There were numerous blood stains from bed bug excrement on his top sheet, fitted sheet and pillowcase. -There were three live bedbugs crawling on the top sheet. Interview with a resident on 08/09/23 at 9:30am revealed: -The medication aide (MA)/Administrator sprayed his bed with bed bug spray whenever she saw a bed bug on his bed. -He used the bedbug spray a few times a week on his sheets and pillowcase. -When he saw a bedbug, he would knock it off the bed. -He got bit every night and woke up itching on his arms, stomach, back and the back of his neck. -It was difficult for him to sleep well at night because he felt bugs biting him and it made him twist and turn in the bed and caused him to itch. -Some nights the bedbugs were so bad that he would get out of his bed, turn the light on and use his hand to brush the bedbugs off his bed. -He observed bedbugs on crawling on his bed and his bedroom wall most days and nights. -The MA/Administrator took his mattress outside three times a month to spray it with bedbug spray and let it sit in the sun to help get rid of the bedbugs and roaches. -The MA/Administrator told him that the sun on his mattress helped bring the bedbugs and roaches out of his mattress. -The bedbugs had bitten him every night for approximately two months. -When he saw a roach on the floor during the daytime, he would step on them to kill it. -He had observed roaches in his bedroom, the kitchen, dining room, bathroom and living room.	C 311		

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C 311	Continued From page 52 -He was used to stepping on roaches in the home to kill them because he saw them so frequently. -He had told the MA/Administrator at least once a week for the past two months that there were bedbugs and roaches in the facility, that he was having trouble sleeping due to the bugs and he was itching. Review of a Resident Health Service Record dated 05/17/23 revealed: -The form was taken to resident medical appointments for the physician to make notes about a resident's visit. -There was a handwritten note by the residents primary care provider (PCP) dated 05/17/23 that the resident was seen for a routine visit and checkup. -There was documentation that bedbug bites were noted, and the facility needs to be treated. -There was documentation that the resident could receive hydrocortisone cream for the itching (Hydrocortisone cream is used to reduce swelling, itching and redness from insect bites). Interview with the MA/Administrator on 08/09/23 at 2:15pm revealed: -She was not aware of what bedbug excrement looked like on resident sheets. -She provided the resident with assistance bathing his back and behind his neck but had not noticed any bumps from bedbug bites. -The resident had complained of itching in May 2023 when he went to his primary care provider (PCP). -The PCP recommended that she apply hydrocortisone to the residents' arms, and back of his neck in the morning and before bedtime daily until the resident stopped itching (hydrocortisone cream is a topical steroid used to treat itching, swelling and redness on this skin).	C 311		

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C 311	Continued From page 53 -She used the tube of hydrocortisone cream and did not purchase another hydrocortisone cream for the resident after she used the first tube of cream. -Since the resident did not complain of bedbug bites and itching, she did not get another tube of hydrocortisone cream. -She was not aware that the resident was still getting bitten by bedbugs and itching. -The resident had not complained about difficulty sleeping due to bugs in his room or itching. A second interview with the resident on 08/10/23 at 2:15pm revealed: -The MA/Administrator applied hydrocortisone cream to his arms, back, and neck yesterday and last night. -He was not itching as bad today as he was over the past few months. -He slept good last night and felt that the cream he received helped his itching improve. Observation of the second resident's bedroom on 08/09/23 at 9:48am revealed: -There were dead roaches in two windowsills. -There were two bed bugs observed crawling on the top sheet. Interview with the second resident on 08/09/23 at 2:55pm revealed: -She observed bedbugs on her bed a few times a week. -She had noticed more bedbugs on her comforter, sheets and pillow the past three weeks. -She itched sometimes on her arms, back and neck but did not think she had been bitten by bedbugs. -She itched several times during the day and at night, but after she put lotion on, it seemed to	C 311		

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C 311	Continued From page 54 help. Interview with the third resident on 08/09/23 at 9:45am revealed: -He had been at the home for about one and half months. -He had to step on roaches on his bedroom floor when he saw them to kill them. -He reported the roaches to the MA/Administrator a few days ago. -An exterminator came to spray the home two days ago. Interview with a fourth resident on 08/10/23 at 2:40pm revealed: -She had problems with itching on her arms, legs and back for about three months. -She could not remember if she had informed the MA/Administrator about her problems with itching. -She saw roaches all over the home every day. -Since the exterminator came to spray the home last week (08/04/23) the roaches seemed to be better. -She stopped accepting donated clothes at the home because she is afraid bugs could be in the clothes. -The MA/Administrator usually reminded them to shake their clothes and hair before they came back into the home after her day program or visiting others. -The staff at the day program she attends five days a week used a lint brush to check for bedbugs on her clothes. -When she saw a bedbug on her bed, she would use her hand to knock them to the floor and try to kill them. Interview with a fifth resident at the facility on 08/09/23 at 9:50am revealed: -He observed roaches in his bedroom, the	C 311		

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resident bathroom, the kitchen, and the dining room daily.
-He killed a roach with a napkin a few days ago when he was eating breakfast at the dining room table because it was crawling toward his plate.
-An exterminator had sprayed the facility a few days ago but he had not noticed a change in the roach activity.

Telephone interview with a local exterminator on 08/10/23 at 12:29pm revealed:
-He had treated the home for bedbug activity during May 2022.
-During his treatment of the home in May 2022 he observed bedbug activity in multiple rooms.
-There was a bedbug infestation in the home when he treated it in May 2022.
-Bedbug activity in the home could affect the residents mentally due to the stress and anxiety of seeing bedbugs in the home and itching after being bit at night while they slept.

Telephone interview with the facility's contracted pest control company on 08/11/23 at 10:17am revealed:
-She provided the first treatment of the home for roaches and rodents on 08/04/23.
-There was an infestation of cock roaches and rodents.
-When cock roaches are observed with lights on the infestation is considered very bad because cock roaches were nocturnal and usually only came out at night.
-The infestation in the kitchen caused health concerns for the residents and anyone eating at the home due to her observation of numerous live roaches, their casings, and their excrement.
-Due to the cock roach infestation in the home food should not be prepared in the kitchen to prevent residents from becoming sick.

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C 311	Continued From page 56 -She observed live bedbugs and bedbug excrement in each residents' rooms, the MA/Administrators bedroom, and an elderly family members bedroom. Telephone interview with a receptionist at the resident's primary care provider (PCP) on 08/09/23 at 11:18am revealed: -Any residents from the home had their medical record was flagged that the home had bedbug activity. -The medical records were flagged so that staff at the PCP office knew to take extra precautions to prevent bedbugs from spreading to the PCP office. Telephone interview with a medical assistant at the resident's PCP on 08/09/23 at 11:36am revealed: -A resident was seen by the PCP for a follow up visit with the MA/Administrator on 05/17/23 complained of not sleeping well due to itching around his neck and arms. -There was documentation in the PCP notes that the resident complained of bedbug bites and itching. -Bedbugs could cause the resident to have excessive itching which could lead to a skin infection such as methicillin-resistant staphylococcus aureus (MRSA), (MRSA is a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). -Bedbugs also placed the resident at risk of vancomycin-resistant enterococci (VRE) and spread from person to person, (VRE is a type of bacteria that is resistant to many antibiotics, including vancomycin). -The resident could become septic from these infections if left untreated.	C 311		

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-When residents from the home had appointments with the PCP, their charts were flagged due to bedbug activity.
-Staff had to disinfect the room that residents from the home were seen in to prevent bedbugs at the provider's practice.
-When residents from the home had appointments at the PCP's office, the residents and MA/Administrator were asked to wait in the vehicle until they were called in to see the PCP to prevent the spread of bedbugs in the waiting room.

Telephone interview with a resident's PCP on 08/09/23 at 11:50am revealed:
-The resident had a follow up visit with her on 05/17/23 for difficulty sleeping and itching.
-The resident had two bedbugs crawling on his clothing at the visit.
-The resident had bedbug bites on his arms and the back of his neck.
-She provided the medication aide (MA)/Administrator with a handwritten summary visit on the facility's Resident Health Service progress note.
-She documented and verbally communicated with the MA/Administrator that the resident had bedbug bites that caused his itching and difficulty sleeping.
-She documented and verbally explained to the MA/Administrator that the facility needed to be treated for bedbugs and she could apply hydrocortisone cream to areas the resident is itching to help reduce the itching and discomfort.
-Resident #2 had a diagnosis of Alzheimer's dementia and was at a higher risk of a skin infection due to the resident not remembering how often or how hard he scratched an area of his skin.
-Bedbugs caused the resident to have increased

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C 311	Continued From page 58 insomnia which aggravated his memory problems and increased his confusion. -If bedbug bites were left untreated could cause severe skin infections from a resident itching excessively. -A secondary skin infection from excessive scratching of bedbugs could cause a bacterial skin infection that if left untreated could become septic. -Roaches, roach casings and roach excrement around food could cause methicillin-resistant staphylococcus aureus (MRSA), (MRSA is a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections). -Roaches, roach casings and roach excrement around food could cause vancomycin-resistant enterococci (VRE) and spread from person to person easily, (VRE is a type of bacteria that is resistant to many antibiotics, including vancomycin). -Roaches, roach casings and roach excrement around food could cause Escherichia coli (E. coli is a severe form of bacteria that can severe food poisoning) and if left untreated could become septic and could be fatal. -Roaches, roach casings and roach excrement around food could cause Salmonella (Salmonella is an infection that can cause diarrhea, fever and stomach pains.) -She explained to the MA/Administrator that the home needed to be treated for bedbugs and roaches as soon as possible to prevent infection for the residents. Interview with the MA/Administrator on 08/09/23 at 10:11am revealed: -An exterminator came to treat the facility for roaches and rodents on 08/04/23. -She did not think that an exterminator had been	C 311		

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C 311	Continued From page 59 to the facility since COVID. -She contacted an exterminator because she started seeing more and more roaches and mice droppings. A second interview with the MA/Administrator on 08/09/23 at 2:15pm revealed: -She noticed increased roach and bedbug activity in July 2023. -She observed roaches crawling on walls in the dining room, resident rooms, and the kitchen. -She observed roaches crawling on the floor throughout the home. -When she saw a roach on the floor, she would "stomp" them with her foot to kill them. -She had attempted to contact several exterminators since July 2023 but had not been able to get any of them to return her call. -She called an exterminator company again two weeks ago and an exterminator came on 08/04/23 to treat the home for roaches and rodents. -She observed what she thought was a bedbug on the wall of the bedroom where two female residents resided several months ago. -She removed the bug from the wall, placed the bug in a plastic bag, showed it to a friend and asked what type of bug it was. -She then took the bug in the plastic bag to a local hardware store to help identify the bug. -The local hardware store provided her with recommendations on how to treat bedbugs. -She and the residents had to leave the home at 9:00am and returned at 1:00pm when she set off foggers in the home to treat the bedbugs. -She had last seen a bedbug in the female resident's room on top of a wig mannequin two weeks ago. -She sprayed areas of the home with bedbug spray to help treat the bedbugs.	C 311		

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C 311	Continued From page 60 -She knew that bedbugs came out and night and bit individuals, but no residents had reported any bites to her. -She checked resident beds for bedbugs every day, which included checking the comforter, sheets, mattress, and pillow. -She pulled the corners of the sheet back to check the crevices of the mattress and had not seen any bedbugs in a month. -She paid a local exterminator company she thought in May 2023 and the home was treated by an exterminator in May 2023 for bedbugs. -The local exterminator had instructed her to treat all linens and clothing by removing them in bags from the home and drying them in a dryer to kill the bedbugs with heat. A third Interview with the MA/Administrator on 08/11/23 at 4:30pm revealed: -She sprayed the house daily with roach spray and bedbug spray to help kill the roaches and bedbugs in the home. -She purchased 15 cans of roach and bedbug spray last week to use at the home. -She changed each residents bedlinens daily, washed the bedlinens and put the bedlinens on the clothesline to dry. -She had three dryers on the property but only one was working. -She only took bedlinens and clothes to the laundromat in the winter months because she did not use the clothesline to dry clothes in the winter months. _____ The facility failed to ensure the residents were free from exploitation when required by the MA/Administrator to perform various chores including climbing a ladder to clean out the gutters, cleaning out cabinets which were infested with roaches, changing all the bed linens, having	C 311		

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C 311	Continued From page 61 to mow the lawn with a push mower and taking all the trash to the dump weekly. The residents who participated in completing the chores were compensated with a popsicle, ice cream and rarely money. The residents who did not or could not participate in performing the chores were admonished, not compensated and left feeling hurt. Female residents were asked by the MA/Administrator to sit with her elderly family member when she left the home, and provide incontinence care for the family member. The facility's failure resulted in serious exploitation of residents and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/09/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2023.	C 311		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	C 315		

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C 315	Continued From page 62 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to obtain clarification for 1 of 3 (#2) sampled residents related to an order from the primary care provider (PCP) for the resident to receive an anti-itch cream to help reduce itching. The findings are: Review of Resident #2's current FL-2 dated 03/08/23 revealed: -Diagnoses included Alzheimer's dementia, hypertension, seasonal allergies, gastroesophageal reflux disease (GERD), and insomnia. -The resident was intermittently disoriented and ambulatory. Review of Resident #2's record on 08/09/23 revealed: -There was a resident health service record form dated 05/17/23 with documentation from the resident's PCP about his appointment on 05/17/23. -There was a handwritten note by Resident #2's PCP dated 05/17/23 that the resident was seen for a routine visit and checkup. -There was documentation that bedbug bites were noted on the resident, and the facility needed to be treated for bedbugs. -There was documentation that the resident could receive hydrocortisone cream for the itching from the bedbug bites (Hydrocortisone cream is used to reduce swelling, itching and redness from insect bites).	C 315		

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C 315	Continued From page 63 Interview with Resident #2 on 08/09/23 at 9:30am revealed: -He observed bedbugs crawling on his bed and his bedroom wall most days and nights. -When he saw a bedbug, he would knock it off the bed. -He got bit every night and woke up itching on his arms, stomach, back and the back of his neck. -It was difficult for him to sleep well at night because he felt bugs biting him and it made him twist and turn in the bed and caused him to itch. -The bedbugs had bitten him every night for approximately two months. -He had told the MA/Administrator at least once a week for the past two months that there were bedbugs in the facility, that he was having trouble sleeping due to the bugs and he was itching. -The MA/Administrator applied an antiitch cream to his arms, back of his neck and back after his last visit with the PCP several months ago. -The anit-itch cream helped him sleep better, but he had not had the anti-itch cream applied in several months. Observation of the medication room on 08/09/23 at 3:03pm with the MA/Administrator revealed the facility did not have a supply of hydrocortisone available for Resident #2. Interview with the MA/Administrator on 08/09/23 at 2:15pm revealed: -Resident #2 had complained of itching in May when he went to his primary care provider (PCP). -The PCP recommended that she apply hydrocortisone to the residents' arms, and back of his neck in the morning and before bedtime daily until the resident stopped itching. -She used one tube of hydrocortisone cream and did not purchase another tube of hydrocortisone cream for the resident after she used the first	C 315		

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tube of cream.
-Since the resident did not complain of bedbug bites and itching, she did not purchase another tube of hydrocortisone cream to continue applying the cream.
-She was not aware that Resident #2 was still getting bitten by bedbugs and itching.
-Resident #2 had not complained about difficulty sleeping due to bugs in his room or itching.

A second interview with Resident #2 on 08/10/23 at 2:15pm revealed:
-The MA/Administrator applied hydrocortisone cream to his arms, back, and neck yesterday and last night.
-He was not itching as bad today as he was over the past few months.
-He slept good last night and felt that the cream he received helped his itching improve.

A third interview with the MA/Administrator on 08/11/23 at 4:30pm revealed:
-She did not think that she needed to follow up with Resident #2's PCP because he had not complained of itching since she finished the first tube of hydrocortisone she got for the resident in May 2023.
-She did purchase a new tube of hydrocortisone on 08/09/23 once she was notified by the state surveyor that the resident was still itching due to the reported bedbug bites he was getting at night.
-She applied the hydrocortisone cream to his arms, back and back of neck two times yesterday and this morning the resident he told her his itching was better.
-She should have checked on Resident #2 to see if he was still getting bit at night by bedbugs and if he was still itching after she completed administering the first tube of hydrocortisone cream.

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C 315	Continued From page 65 Telephone interview with Resident #2 PCP on 08/09/23 at 11:50am revealed: -Resident #2 had a follow up visit with her on 05/17/23 for difficulty sleeping and itching. -The resident had two bedbugs crawling on his clothing at the visit. -The resident had bedbug bites on his arms and the back of his neck. -She provided the medication aide MA/Administrator with a handwritten summary visit on the facility's Resident Health Service progress note. -She documented and verbally communicated with the MA/Administrator that the resident had bedbug bites that caused his itching and difficulty sleeping. -She could apply hydrocortisone cream to areas the resident was itching to help reduce the itching and discomfort. -Resident #2 had a diagnosis of Alzheimer's dementia and was at a higher risk of a skin infection due to the resident not remembering how often or how hard he scratched an area of his skin. -Bedbugs caused the resident to have increased insomnia which aggravated his memory problems and increased his confusion. -If bedbug bites were left untreated could cause severe skin infections from a resident itching excessively. -A secondary skin infection from excessive scratching of bedbugs could cause a bacterial skin infection that if left untreated could become septic. -She explained to the MA/Administrator that the home needed to be treated for bedbugs and roaches as soon as possible to prevent infection for the residents. _____	C 315		

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C 315	Continued From page 66 The facility failed to ensure an order for hydrocortisone cream was clear and complete to include frequency, location and duration of an antiitch cream. The MA/Administrator purchased and applied one tube only which resulted in Resident #2 waking up with itching on his arms, stomach, back and the back of his neck every night and it made it difficult to sleep for months. Bedbugs caused the resident to have increased insomnia which aggravated his memory problems and increased his confusion This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2023.	C 315		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	C 341		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure staff documented the administration of medications immediately following the observation of the resident taking the medication for 3 of 3 sampled residents (#1, #2, #3).

The findings are:

Review of the facility's medication policy and procedure manual, not dated, revealed recording of any administration must be recorded prior to the next scheduled administration.

1. Review of Resident #1's current FL-2 dated 06/09/23 revealed:
-Diagnoses included unspecified anxiety disorder and insomnia.
-There was an order for lorazepam (used to treat anxiety) 1 tablet 3 times a day.
-There was an order for Ambien (used to treat insomnia) 1 tablet at bedtime as needed.
-There was an order for Lexapro (used to treat anxiety) 20mg daily.
-There was an order for Zyprexa (used to treat schizophrenia and bipolar disorder) 7.5mg twice a day.

Review of Resident #1's electronic prescription dated 06/09/23 revealed there was an order for Ambien 5mg at bedtime as needed for sleep.

Review of Resident #1's second electronic prescription dated 06/09/23 revealed there was an order for lorazepam 1mg 3 times a day.

Review of Resident #1's electronic prescription dated 06/15/23 revealed there was an order for Vitamin D3 (a supplement) 125mcg daily.

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C 341	Continued From page 68 Review of Resident #1's June 2023 medication administration record (MAR) revealed: -No medications were documented as administered 06/01/23 to 06/09/23 due to the resident being out of the facility. -There was an entry for lorazepam 1mg 3 times a day for anxiety scheduled for administration at 8:00am, 12:00pm, and 8:00pm. -Lorazepam 1mg was documented as administered at 8:00am and 12:00pm on 06/10/23 to 06/20/23. -Lorazepam 1mg was documented as administered at 8:00pm on 06/10/23 to 06/19/23. -Lorazepam 1mg was not documented as administered at 8:00am and 12:00pm on 06/21/23 to 06/30/23 and at 8:00pm on 06/20/23 to 06/30/23. -There was an entry for Ambien 5mg at bedtime as needed scheduled for administration at 8:00pm. -Ambien 5mg was documented as administered at 8:00pm on 06/10/23 to 06/19/23. -Ambien 5mg was not documented as administered at 8:00pm on 06/20/23 to 06/30/23. -There was an entry for Lexapro 20mg every day for depression scheduled for administration at 8:00am. -Lexapro 20mg was documented as administered at 8:00am on 06/10/23 to 06/12/23. -Lexapro 20mg was not documented as administered at 8:00am on 06/13/23 to 06/30/23. -There was an entry for Zyprexa 7.5mg twice a day for mood scheduled for administration at 8:00am and 8:00pm. -Zyprexa 7.5mg was documented as administered at 8:00am on 06/10/23 to 06/19/23 and at 8:00pm on 06/09/23 to 06/19/23. -Zyprexa 7.5mg was not documented as administered at 8:00am and 8:00pm on 06/20/23	C 341		

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to 06/30/23.
-There was no entry for Vitamin D3 125mcg daily.

Review of a controlled drug record for Ambien 5mg for Resident #1 revealed it was recorded that Resident #1 received 1 tablet of Ambien 5mg on 06/09/23 to 06/21/23.

Review of Resident #1's July 2023 MAR revealed:
-There was an entry for Ambien 5mg at bedtime as needed for sleep.
-Ambien 5mg was not documented as administered 07/01/23 to 07/31/23.

Review of Resident #1's August 2023 MAR on 08/11/23 at 10:20am revealed:
-There was an entry for lorazepam 1mg 3 times a day for anxiety scheduled for administration at 8:00am, 12:00pm, and 8:00pm.
-Lorazepam 1mg was documented as administered at 8:00am and 12:00pm on 08/01/23 to 08/10/23 and at 8:00pm on 08/01/23 to 08/09/23.
-Lorazepam 1mg was not documented as administered at 8:00am on 08/11/23 and at 8:00pm on 08/10/23.
-There was an entry for Ambien 5mg at bedtime as needed for sleep scheduled for administration at 8:00pm.
-Ambien 5mg was not documented as administered at 8:00pm on 08/01/23 to 08/10/23.
-There was an entry for Lexapro 20mg every day for depression scheduled for administration at 8:00am.
-Lexapro 20mg was documented as administered at 8:00am on 08/01/23 to 08/10/23.
-Lexapro 20mg was not documented as administered at 8:00am on 08/11/23.
-There was an entry for Zyprexa 7.5mg twice a day for mood scheduled for administration at

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8:00am and 8:00pm.
-Zyprexa 7.5mg was documented as administered at 8:00 am on 08/01/23 to 08/10/23 and at 8:00pm on 08/01/23 to 8/09/23.
-Zyprexa 7.5mg was not documented as administered at 8:00am on 08/11/23 and at 8:00pm on 08/10/23.
-There was an entry for Vitamin D3 125mcg daily for supplement scheduled for administration at 8:00am.
-Vitamin D3 125mcg was documented as administered at 8:00am on 08/01/23 to 08/10/23.
-Vitamin D3 125mcg was not documented as administered at 8:00am on 08/11/23.

Observation of Resident #1's medications on hand on 08/11/23 at 10:42am revealed:
-There was a medication card containing 81 tablets of lorazepam 1mg dispensed on 08/07/23.
-There was a medication card containing 1 tablet of Lexapro 20mg dispensed on 07/14/23.
-There was a medication card containing 4 tablets of Zyprexa 7.5mg dispensed on 07/14/23.
-There was a medication card containing 2 tablets of Vitamin D3 dispensed on 07/14/23.
-There was no medication card containing Ambien 5mg.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/11/23 at 11:57am revealed:
-Ninety-three tablets of lorazepam 1mg were dispensed for Resident #1 on 06/09/23.
-Ninety-three tablets of lorazepam 1mg were dispensed for Resident #1 on 07/06/23.
-Thirty tablets of Lexapro 20mg were dispensed for Resident #1 on 06/12/23.
-Thirty tablets of Ambien 5mg were dispensed for Resident #1 on 06/09/23.
-Ambien 5mg had not been dispensed for

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C 341	Continued From page 71 Resident #1 since 06/09/23. -Sixty tablets of Zyprexa 7.5mg were dispensed for Resident #1 on 06/12/23. -Twenty-eight tablets of Vitamin D 125mcg were dispensed for Resident #1 on 06/15/23. Interview with Resident #1 on 08/11/23 at 10:54am revealed: -He received all his medications last night and this morning. -He used to ask for Ambien every night, but he stopped asking for his Ambien because he was not having trouble sleeping and did not need it anymore. -He was not sure when the last time was that he took Ambien, but it had been at least a month or more. Second interview with Resident #1 on 08/11/23 at 3:08pm revealed he had not ever been out of his medications several days in a row. Interview with the medication aide (MA)/Administrator on 08/11/23 at 12:14pm revealed: -She was the only staff who administered medications to residents. -She did not know why she did not document that she administered Resident #1's medications to him some days in June 2023. -She knew she administered Resident #1's medications to him every day in June 2023 because she had the medications there to administer. -She administered Resident #1's evening medications last night and his morning medications this morning. -She had a long day yesterday and was too tired to document that she had administered Resident #1's medications to him last night.	C 341		

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C 341	Continued From page 72 -She took a resident to a doctor's appointment this morning and was in a rush to get out of the house on time, so she did not document that she administered Resident #1's medications this morning. -She meant to go back and document that she administered Resident #1's medications, and she forgot to do so. -When Resident #1 returned from the hospital on 06/09/23 he wanted his Ambien every night. -Resident #1 eventually stopped taking Ambien 5mg because he said he was not having trouble sleeping anymore. -She knew she had administered all of Resident #1's Ambien to him but she must not have documented on the MAR when she administered it to him. -She should have documented on the MAR when she administered it and she was not sure why she did not document it. -She was not sure why she documented on Resident #1's control log that he received Ambien 5mg on 06/20/23 and 06/21/23 but did not document it on his MAR. -It was important to document that she had administered a medication as soon as it was administered because when she did not document it looked like the resident did not receive their medications. 2. Review of Resident #2's current FL-2 dated 03/08/23 revealed: -Diagnoses included Alzheimer's dementia, hypertension, seasonal allergies, and gastroesophageal reflux disease (GERD). -There was an order for Namenda (used to treat Alzheimer's disease) 10mg twice daily. -There was an order for Pepcid (used to treat GERD) 20mg twice a day. -There was an order for Xyzal (used to treat	C 341		

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seasonal allergies) 5mg every morning.
-There was an order for Prilosec (used to treat GERD) 20mg every morning.
-There was an order for trazodone (used to treat depression) 50mg at bedtime.
-There was an order for aspirin (used to treat mild pain or thin the blood) 81mg daily.
-There was an order for valsartan-hydrochlorothiazide (HCTZ) (used to treat hypertension) 160-12.5mg daily.

Review of Resident #2's June 2023 medication administration record (MAR) revealed:
- There was an entry for valsartan-HCTZ 160-12.5 every day scheduled for administration at 8:00am.
-Valsartan-HCTZ 160-12.5 was documented as administered at 8:00am on 06/01/23 to 06/22/23.
-Valsartan-HCTZ 160-12.5 was not documented as administered at 8:00am 06/23/23 to 06/30/23.
-There was an entry for aspirin 81mg every day scheduled for administration at 8:00am.
-Aspirin 81mg was documented as administered at 8:00am on 06/01/23 to 06/22/23.
-Aspirin 81mg was not documented as administered at 8:00am on 06/23/23 to 06/30/23.
-There was an entry for Prilosec 20mg every morning scheduled for administration at 8:00am.
-Prilosec 20mg was documented as administered at 8:00am on 06/01/23 to 06/22/23.
-Prilosec 20mg was not documented as administered at 8:00am on 06/23/23 to 06/30/23.
-There was an entry for Namenda 10mg 2 times a day scheduled for administration at 8:00am and 8:00pm.
-Namenda 20mg was documented as administered at 8:00am on 06/01/23 to 06/22/23 and at 8:00pm on 06/01/23 to 06/21/23.
-Namenda 20mg was not documented as administered at 8:00am on 06/23/23 to 06/30/23

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and at 8:00pm on 06/22/23 to 06/30/23.
-There was an entry for Pepcid 20mg 2 times a day scheduled for administration at 8:00am and 8:00pm.
-Pepcid 20mg was documented as administered at 8:00am on 06/01/23 to 06/22/23 and at 8:00pm on 06/01/23 to 06/21/23.
-Pepcid 20mg was not documented as administered at 8:00am on 06/23/23 to 06/30/23 and at 8:00pm on 06/22/23 to 06/30/23.
-There was an entry for trazodone 50mg at bedtime scheduled for administration at 8:00pm.
-Trazodone 50mg was documented as administered at 8:00pm on 06/01/23 to 06/21/23.
-Trazodone 50mg was not documented as administered at 8:00pm on 06/22/23 to 06/30/23.
-There was an entry for Xyzal 5mg every evening scheduled for administration at 8:00pm.
-Xyzal 5mg was documented as administered at 8:00pm on 06/01/23 to 06/21/23.
-Xyzal 5mg was not documented as administered at 8:00pm on 06/22/23 to 06/30/23.

Review of Resident #2's August 2023 MAR on 08/11/23 at 9:28am revealed:
- There was an entry for valsartan-HCTZ 160-12.5 every day scheduled for administration at 8:00am.
-Valsartan-HCTZ 160-12.5 was documented as administered at 8:00am on 08/01/23 to 08/10/23.
-Valsartan-HCTZ 160-12.5 was not documented as administered at 8:00am 08/11/23.
-There was an entry for aspirin 81mg every day scheduled for administration at 8:00am.
-Aspirin 81mg was documented as administered at 8:00am on 08/01/23 to 08/10/23.
-Aspirin 81mg was not documented as administered at 8:00am on 08/11/23.
-There was an entry for Prilosec 20mg every morning scheduled for administration at 8:00am.

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C 341	Continued From page 75 -Prilosec 20mg was documented as administered at 8:00am on 08/01/23 to 08/10/23. -Prilosec 20mg was not documented as administered at 8:00am on 08/11/23. -There was an entry for Namenda 10mg 2 times a day scheduled for administration at 8:00am and 8:00pm. -Namenda 20mg was documented as administered at 8:00am on 08/01/23 to 08/10/23 and at 8:00pm on 08/01/23 to 08/09/23. -Namenda 20mg was not documented as administered at 8:00am on 08/11/23 and at 8:00pm on 08/10/23. -There was an entry for Pepcid 20mg 2 times a day scheduled for administration at 8:00am and 8:00pm. -Pepcid 20mg was documented as administered at 8:00am on 08/01/23 to 08/10/23 and at 8:00pm on 08/01/23 to 08/09/23. -Pepcid 20mg was not documented as administered at 8:00am on 08/11/23 and at 8:00pm on 08/10/23. -There was an entry for trazodone 50mg at bedtime scheduled for administration at 8:00pm. -Trazodone 50mg was documented as administered at 8:00pm on 08/01/23 to 08/09/23. -Trazodone 50mg was not documented as administered at 8:00pm on 08/10/23. -There was an entry for Xyzal 5mg every evening scheduled for administration at 8:00pm. -Xyzal 5mg was documented as administered at 8:00pm on 08/01/23 to 08/09/23. -Xyzal 5mg was not documented as administered at 8:00pm on 08/10/23. Observation of Resident #2's medications on hand on 08/11/23 at 10:39am revealed: -There was a medication card containing 3 tablets of valsartan-HCTZ dispensed on 07/14/23. -There was a medication card containing 1 tablet	C 341		

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of aspirin 81mg dispensed on 07/14/23.
-There was a medication card containing 3 tablets of Prilosec 20mg dispensed on 07/14/23.
-There was a medication card containing 7 tablets of Namenda 10mg dispensed on 07/14/23.
-There was a medication card containing 3 tablets of Pepcid 20mg dispensed on 07/14/23.
-There was a medication card containing 2 tablets of trazodone 50mg dispensed on 07/14/23.
-There was a medication card containing 1 tablet of Xyzal 5mg dispensed on 07/14/23.

Interview with a pharmacist at the facility's contracted pharmacy on 08/09/23 at 4:05pm revealed:
-Thirty tablets of valsartan-HCTZ were dispensed for Resident #2 on 06/12/23.
-Thirty tablets of aspirin 81mg were dispensed for Resident #2 on 06/12/23.
-Thirty tablets of Prilosec 20mg were dispensed for Resident #2 on 06/12/23.
-Sixty tablets of Namenda 10mg were dispensed for Resident #2 on 06/12/23.
-Sixty tablets of Pepcid 20mg were dispensed for Resident #2 on 06/12/23.
-Thirty tablets of trazodone 50mg were dispensed for Resident #2 on 06/12/23.
-Thirty tablets of Xyzal 5mg were dispensed for Resident #2 on 06/12/23.

Interview with Resident #2 on 08/11/23 at 3:07pm revealed:
-He received all his medications last night and this morning.
-He did not remember being out of any of his medications in June 2023.

Interview with the medication aide (MA)/Administrator on 08/11/23 at 12:14pm revealed:

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C 341	Continued From page 77 -She was the only staff who administered medications to residents. -She did not know why she did not document that she administered Resident #2's medications to him some days in June 2023. -She knew she administered Resident #2's medications to him every day in June 2023 because she had the medications there to administer. -She administered Resident #2's evening medications last night and his morning medications this morning. -She had a long day yesterday and was too tired to document that she had administered Resident #2's medications to him last night. -She took a resident to a doctor's appointment this morning and was in a rush to get out of the house on time, so she did not document that she administered Resident #2's medications this morning. -She meant to go back and document that she administered Resident #2's medications, and she forgot to do so. -It was important to document that she had administered a medication as soon as it was administered because when she did not document it looked like the resident did not receive their medications. 3. Review of Resident #3's current FL-2 dated 03/13/23 revealed: -Diagnoses included schizoaffective disorder, anxiety, and Parkinson's disease. -There was an order for metoprolol tartrate (used to treat hypertension) 25mg every day. -There was an order for divalproex (used to treat seizures) 500mg 3 tablets at bedtime. -There was an order for Vitamin D3 (a supplement) 400 units daily. -There was an order for mirtazapine (used to	C 341		

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treat anxiety) 7.5mg nightly.
-There was an order for rosuvastatin (used to treat high cholesterol) 5mg nightly.
-There was an order for benztropine (used to treat Parkinson's disease) 2 mg twice a day.

Review of a physician visit sheet dated 07/13/23 revealed there was an order to discontinue mirtazapine 7.5mg every night.

Review of Resident #3's June 2023 medication administration record (MAR) revealed:
-There was an entry for metoprolol tartrate 25mg every day scheduled for administration at 8:00am.
-Metoprolol tartrate 25mg was documented as administered at 8:00am on 06/01/23 to 06/22/23.
-Metoprolol tartrate 25mg was not documented as administered at 8:00am on 06/23/23 to 06/30/23.
-There was an entry for Vitamin D3 400IU daily scheduled for administration at 8:00am.
-Vitamin D 400IU was documented as administered at 8:00am on 06/01/23 to 06/22/23.
-Vitamin D 400IU was not documented as administered at 8:00am on 06/23/23 to 06/30/23.
-There was an entry for benztropine 2mg 2 times a day scheduled for administration at 8:00am and 8:00pm.
-Benztropine 2mg was documented as administered at 8:00am on 06/01/23 to 06/22/23 and at 8:00pm on 06/01/23 to 06/21/23.
-Benztropine 2mg was not documented as administered at 8:00am on 06/23/23 to 06/30/23 and at 8:00pm on 06/22/23 to 06/30/23.
-There was an entry for divalproex sodium 500mg 3 tablets in the morning scheduled for administration at 8:00am.
-Divalproex sodium 500mg 3 tablets was documented as administered at 8:00am on

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C 341	Continued From page 79 06/01/23 to 06/22/23. -Divalproex sodium 500mg 3 tablets was not documented as administered at 8:00am on 06/23/23 to 06/30/23. -There was an entry for rosuvastatin calcium 5mg at bedtime scheduled for administration at 8:00pm. -Rosuvastatin calcium 5mg was documented as administered at 8:00pm on 06/01/23 to 06/21/23. -Rosuvastatin calcium 5mg was not documented as administered at 8:00pm on 06/22/23 to 06/30/23. -There was an entry for mirtazapine 7.5mg every night at bedtime scheduled for administration at 8:00pm. -Mirtazapine 7.5mg was documented as administered at 8:00pm on 06/01/23 to 06/21/23. -Mirtazapine 7.5mg was not documented as administered at 8:00pm on 06/22/23 to 06/30/23. Review of Resident #3's August 2023 MAR on 08/11/23 at 3:41pm revealed: -There was an entry for metoprolol tartrate 25mg every day scheduled for administration at 8:00am. -Metoprolol tartrate 25mg was documented as administered at 8:00am on 08/01/23 to 08/10/23. -Metoprolol tartrate 25mg was not documented as administered at 8:00am on 08/11/23. -There was an entry for Vitamin D3 400IU daily scheduled for administration at 8:00am. -Vitamin D 400IU was documented as administered at 8:00am on 08/01/23 to 08/10/23. -Vitamin D 400IU was not documented as administered at 8:00am on 08/11/23. -There was an entry for benztropine 2mg 2 times a day scheduled for administration at 8:00am and 8:00pm. -Benztropine 2mg was documented as administered at 8:00am on 08/01/23 to 08/10/23	C 341		

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and at 8:00pm on 08/01/23 to 08/09/23.
-Benztropine 2mg was not documented as administered at 8:00am on 08/11/23 and at 8:00pm on 08/10/23.
-There was an entry for divalproex sodium 500mg 3 tablets in the morning scheduled for administration at 8:00am.
-Divalproex sodium 500mg 3 tablets was documented as administered at 8:00am on 08/01/23 to 08/10/23.
-Divalproex sodium 500mg 3 tablets was not documented as administered at 8:00am on 08/11/23.
-There was an entry for rosuvastatin calcium 5mg at bedtime scheduled for administration at 8:00pm.
-Rosuvastatin calcium 5mg was documented as administered at 8:00pm on 08/01/23 to 08/09/23.
-Rosuvastatin calcium 5mg was not documented as administered at 8:00pm on 08/10/23.

Observation of Resident #3's medications on hand on 08/11/23 at 3:55pm revealed:
-There was a medication card containing 6 tablets of benztropine 2mg dispensed on 07/14/23.
-There was a medication card containing 3 tablets of metoprolol tartrate 25mg dispensed on 07/14/23.
-There was a medication card containing 1 tablet of Vitamin D 400IU dispensed on 07/14/23.
-There was a medication card containing 4 tablets of rosuvastatin 5mg dispensed on 07/14/23.
-There was a medication card containing 5 tablets of divalproex sodium 500mg dispensed on 07/14/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/11/23 at 3:57pm revealed:
-Thirty tablets of metoprolol tartrate 25mg was

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dispensed for Resident #3 on 06/12/23.
-Ninety tablets of divalproex sodium 500mg were dispensed for Resident #3 on 06/12/23.
-Thirty tablets of Vitamin D3 400IU was dispensed for Resident #3 on 06/12/23.
-Thirty tablets of mirtazapine 7.5mg was dispensed for Resident #3 on 06/12/23.
-Thirty tablets of rosuvastatin calcium 5mg was dispensed for Resident #3 on 06/12/23.
-Sixty tablets of benztropine 2mg was dispensed for Resident #3 on 06/12/23.

Interview with Resident #3 on 08/11/23 at 3:09pm revealed:
-She received all her medication this morning and last night.
-She did not recall ever being out of medication in June 2023.

Interview with the medication aide (MA)/Administrator on 08/11/23 at 4:44pm revealed:
-She did not know why she did not document that she administered Resident #3's medications to her some of the days in June 2023 but she knew she administered them.
-She administered Resident #3's evening medications last night and her morning medications this morning.
-She was too tired last night and too busy this morning to document that she administered Resident #3's medications.
-She meant to go back and document that she administered Resident #3's medications, and she forgot to do so.
-She should always document that she administered a medication as soon as it was administered.

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C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#1) who did not have a new medication added to the medication administration record (MAR). The findings are: Review of Resident #1's current FL-2 dated 06/09/23 revealed diagnoses included unspecified anxiety disorder and insomnia.	C 342		

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C 342	Continued From page 83 Review of Resident #1's electronic prescription dated 06/15/23 revealed there was an order for Vitamin D3 (a supplement) 125mcg daily. Review of Resident #1's June 2023 medication administration record (MAR) revealed there was no entry for Vitamin D3 125mcg daily. Observation of Resident #1's medications on hand on 08/11/23 at 10:42 am revealed: -There was an empty medication card of Vitamin D3 125mcg that was dispensed on 06/15/23. -There was a medication card containing 2 tablets of Vitamin D3 dispensed on 07/14/23. Interview with the medication aide (MA)/Administrator on 08/11/23 at 12:14pm revealed: -When a resident received a new medication order the primary care provider (PCP) sent the prescription to the facility's contracted pharmacy to be filled. -The pharmacy put resident's medications on the MAR. -If a resident was prescribed a new medication after the MARs were printed by the pharmacy it was her responsibility to put the new medication on the MAR. -She did not know why she did not put Resident #1's order for Vitamin D3 on the MAR. -She administered Resident #1's Vitamin D3 in June 2023 because the pharmacy sent it to be administered. -She was the only staff at the facility who administered medications. -A nurse came 4 times a month to review resident's MARs. -The nurse came to the facility in June 2023, so she was not sure why she did not put Resident #1's Vitamin D3 on the MAR.	C 342		

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C 342	Continued From page 84 Telephone interview with the facility's contracted nurse on 08/11/23 at 3:16pm revealed: -She came to the facility and reviewed resident's MARs weekly. -When she reviewed the MARs, she checked resident's medications on hand and compared them to the PCP orders and what was on the MAR. -The facility's contracted pharmacy printed out resident MARs. -If a resident received a new order for a medication after the pharmacy had printed out MARs it was the facility's responsibility to add the medication to the MAR. -If she checked a resident's MAR and saw that there was a new medication that was not added to the MAR, she would add it herself. -She did not know why she did not add Resident #1's Vitamin D3 to his MAR in June 2023. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/11/23 at 11:57am revealed: -The pharmacy printed resident MARs monthly. -If a resident received a new medication order after the MARs were printed it was the facility's responsibility to add the new medication to the MAR.	C 342		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.	C 353		

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C 353	Continued From page 85 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure medications were maintained locked and secured when not supervised by staff. The findings are: Observation of the medication room on 08/09/23 at 7:35am revealed: -The medication room was located across from a resident room where two residents resided and by a second resident room where one resident resided. -Residents had to pass the small hallway to the right where the medication room was located to use the community restroom. Observation of the medication room on 08/09/23 7:36am revealed: -The door to the medication room was cracked open and there were keys in the doorknob. -There was a bubble medication card with Lorazepam 1mg, with 90 tablets in the bubble card on top of the desk (Lorazepam is used to treat anxiety). -There were two medication lids in an open desk drawer. -One medication lid had three gel pills, one round white pill, and on dark orange pill sitting in the lid. -The second medication lid had three round peach pills, five round yellow pills, and three oval pink pills sitting in the lid. Interview with the medication aide (MA)/Administrator at 7:38am revealed: -The door to the medication room was unlocked because she had just gone in the room to get a	C 353		

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resident his morning medications.
-She did not realize that there was a bubble medication card with a controlled medication on top of the desk.
-She always kept the medication room locked and had forgotten to remove her keys from the doorknob.
-She was not sure who the medications in the pill lids in the desk drawer belonged to or what medications they were.
-She had evidently put the medications in the pill lids in the desk drawer and forgotten them.
-Residents knew to stay out of the medication room because it was always locked.

Observation of a four tiered shelf in the kitchen on 08/09/23 at 7:44am revealed:
-There was a tube of Ketoconazole cream 2% without a lid located on the third shelf (Ketoconazole cream is used to treat infections caused by a fungus or yeast).
-There was a label on the medication for a resident that did not reside at the home that was dated 01/17/21.

Interview with the MA/Administrator on 08/09/23 at 7:46am revealed she did not know who the Ketoconazole cream 2% belonged to and did not recognize the name on the medication.

Observation of the kitchen on 08/09/23 at 7:58am revealed:
-There was a blue pill container on the kitchen counter to the left of the refrigerator.
-The blue pill container had four areas for medications marked with morning, noon, evening, and bedtime.
-There was one round pill, one blue capsule, two round yellow pills, and one white oval pill in the portion of the pill box marked morning.

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C 353	Continued From page 87 -There was one round peach pill and one blue capsule in the portion of the pill box marked noon. -There was one round green pill and one oval white pill in the portion of the pill box marked bedtime. Interview with the MA/Administrator at 7:59am revealed: -The medications in the blue pill container belonged to her. -She always kept them in the kitchen on the counter so she could take her medications when she prepared the residents breakfast. -She did not realize that her personal medications needed to be in a secure location. Observation of the stove in the kitchen on 08/09/23 at 8:15am revealed there was a round white pill on top of aluminum foil at the center of the stove. Interview with the MA/Administrator at 8:16am revealed: -The medication on the stove was her Metformin (Metformin is a medication used to control blood sugar). -She had forgotten to take it earlier this morning when she was preparing the resident's breakfast; she had placed it on the stove and forgotten to take the medication. Observation of the refrigerator in the kitchen on 08/09/23 at 8:20am revealed: -The refrigerator was not locked and was not located in a locked medication area. -There was a medication box of Trulicity 1.5mg/0.5mL (Trulicity is an injection used to help decrease blood sugars for Type II diabetics) that contained one pen. -There was an insulin pen on the bottom shelf on	C 353		

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C 353	Continued From page 88 the right side of the refrigerator door labeled Toujeo (Toujeo is an injection used to help decrease blood sugars for Type II diabetics). Interview with the MA/Administrator on 08/09/23 at 8:21am revealed she was not aware that insulin pens for residents needed to be locked in a refrigerator. Attempted telephone interview with the primary care provider (PCP) for the home on 08/11/23 at 4:00pm was unsuccessful. _____ The facility failed to ensure medications were maintained under locked security including 90 tablets of a controlled medication, medications that were stored in bottle lids, medications belonging to the Administrator, insulin pens in the unlocked refrigerator and a medication left on a shelf in the kitchen that was unable to be identified by the MA/Administrator. The facility's failure to ensure medications were maintained under locked security locked and secured from residents was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 08/09/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2023.	C 353		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily	C 367		

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C 367	Continued From page 89 retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the retrievable record of controlled substances were maintained and reconciled accurately with the documented administration of a medication used to treat insomnia for 1 of 1 sampled resident (#1) with an order for a controlled substance medication. The findings are: Review of Resident #1's current FL-2 dated 06/09/23 revealed: -Diagnoses included unspecified anxiety disorder and insomnia. -There was an order for Ambien (used to treat insomnia) 1 tablet at bedtime as needed. Review of Resident #1's electronic prescription dated 06/09/23 revealed there was an order for Ambien 5mg at bedtime as needed for sleep. Review of Resident #1's June 2023 medication administration record (MAR) revealed: -There was an entry for Ambien 5mg at bedtime as needed scheduled for administration at 8:00pm. -Ambien 5mg was documented as administered at 8:00pm 06/10/23 to 06/19/23. -Ambien was not documented as administered at 8:00pm on 06/20/23 to 06/30/23.	C 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 90 Review of Resident #1's July 2023 MAR revealed: -There was an entry for Ambien 5mg at bedtime as needed for sleep. -Ambien 5mg was not documented as administered 07/01/23 to 07/31/23. Review of Resident #1's August 2023 MAR on 08/11/23 at 10:20am revealed: -There was an entry for Ambien 5mg at bedtime as needed for sleep scheduled for administration at 8:00pm. -Ambien 5mg was not documented as administered at 8:00pm on 08/01/23 to 08/10/23. Review of a controlled drug record for Ambien 5mg for Resident #1 revealed: -A quantity of 30 tablets of Ambien 5mg was received on 06/09/23. -The first recorded entry was on 06/09/23 at 7:00pm and it was documented there were 30 tablets of Ambien 5mg. -The last recorded entry was on 06/21/23 at 7:00pm and it was documented there were 18 tablets of Ambien 5mg. Observation of Resident #1's medications on hand on 08/11/23 at 10:42am revealed there was no medication card containing Ambien 5mg. Interview with Resident #1 on 08/11/23 at 10:54am revealed: -He used to ask for Ambien every night, but he stopped asking for his Ambien because he was not having trouble sleeping and did not need it anymore. -He was not sure when the last time was that he took Ambien, but it had been at least a month or more. Interview with the medication aide	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 08/11/2023

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C 367	Continued From page 91 (MA)/Administrator on 08/11/23 at 12:14pm revealed: -She was the only staff who administered medications to residents. -When Resident #1 returned from the hospital on 06/09/23 he wanted his Ambien every night. -Resident #1 eventually stopped taking Ambien 5mg because he said he was not having trouble sleeping anymore. -She knew she had administered all of Resident #1's Ambien to him but she must not have documented on the MAR when she administered it to him. -She should have documented on the MAR when she administered it and she was not sure why she did not document it. -She was not sure why she documented on Resident #1's control log that he received Ambien 5mg on 06/20/23 and 06/21/23 but did not document it on his MAR. -Resident #1 saw his mental health provider today, 08/11/23, and he discontinued his Ambien because the resident told him he did not need it anymore. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/11/23 at 11:57am revealed: -Thirty tablets of Ambien 5mg was dispensed for Resident #1 on 06/09/23. -Ambien 5mg had not been dispensed for Resident #1 since 06/09/23. -Medications that were ordered to be administered as needed were not refilled unless it was requested by the facility. -Ambien was a schedule IV controlled substance which meant the medication was less addictive than some other controlled substances. -The pharmacy received a discontinue order for Resident #1's Ambien on 08/11/23.	C 367		

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 367	Continued From page 92 Attempted telephone interview with Resident #1's mental health provider on 08/11/23 at 11:28am was unsuccessful.	C 367		