Division of Health Service Regulation

PRINTED: 07/28/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING _____ B. WING _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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 survey on July 13, 2016.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls and floors of the hallway to the residents' rooms, of the dining room, of the living room, and of the residents' rooms were kept clean and in good repair. The findings are: Observation of the facility on 7/13/16 between 1:00pm and 2:30pm revealed: -The walls of the hallway to the residents' rooms, of the dining room, of the living room, and of the residents' rooms had scrapes in the drywall. The walls and light switch plates throughout the facility were discolored with brown-gray marks with fingerprints, handprints, and dust. -There were patched holes in the walls throughout the facility that appeared to be from the door knob hitting the walls. The patched holes were not finished to be smooth with the walls nor painted. -Facility floors were dull in appearance, with dust along the edges of the floors. -Dead crickets were observed on the floor in resident rooms. -The windows throughout the facility were dirty	C 074	Walls will be repaired per construction guidelines by qualified staff 9/30/16 walls and light switch plates will be cleaned and/or replaced 9/30/16 - patched holes will be repaired and painted to match walls 9/30/16 - floors will be cleaned/buffed and swept to avoid debris	

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

STATE FORM 6899 WV7711 If continuation sheet 1 of 7

Reviewed and accepted

2-12-17

Division of Health Service Regulation

PRINTED: 07/28/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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 074	Continued From page 1	C 074		

with smears of dust and debris.
-The doors throughout the facility were dirty and felt greasy and sticky when touched, with gray marks and streaks of dirt.
-The facility door frames and area around the door knobs were blackened from handprints.
-An electrical outlet cover in the dining room was broken on the upper right corner, exposing the metal interior of the outlet.

Interview with the Administrator at 5:00pm on 7/13/16 revealed:
-She was aware there were areas of repair to address.
-The scrapes in the walls of the facility were caused by residents who scraped the walls when using their wheelchairs.
-She would like to repaint and repair the facility's interior.
-She had tried to get repairs made, but was having difficulty getting the fiduciary of the estate (which owned the building and license) to provide funds for repairs/maintenance.
-The facility had a maintenance person who took care of several buildings owned by the licensee.
-She did not have a deep cleaning schedule.
-None of the residents had complained about the facility's condition.

Confidential interviews with 3 residents revealed:
-They were not bothered by the current condition of the facility.
-The facility needed "some upkeep".
-They enjoyed living at the facility.
-Facility staff "tidy up" the facility by straightening up furniture, wet-mopping the floors, cleaning bathrooms, and removing clutter and trash out of the facility.

-All windows will be cleaned 9/30/16
- All doors and walls will be thoroughly cleaned to remove debris/handprints 9/30/16
- outlet cover will be replaced
- Administrator will oversee repairs and monitor cleanliness of building to ensure that building remains clean on a weekly basis 9/30/16

PRINTED: 07/28/2016
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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 076	Continued From page 2	C 076		
C 076	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings	C 076		

10A NCAC 13G .0315 Housekeeping and Furnishings
(a) Each family care home shall:
(3) have furniture clean and in good repair:
This Rule shall apply to new and existing homes.

This Rule is not met as evidenced by:
Based on observation and interviews, the facility failed to assure the kitchen cabinets and oven were kept clean and in good repair.

The findings are:

Tour of the facility kitchen at 12noon on 7/13/16 revealed:
-Kitchen cabinets and drawers were littered with spills, food particles, dust and debris inside.
-Kitchen cabinet doors were greasy to the touch and had gray-brown streaks on the surfaces.
-Knobs were missing from kitchen cabinets.
-The kitchen oven was greasy and black with burned-on food.

-Interview with the Personal Care Aide at 12:45pm on 7/13/16 revealed:
-He provided personal care, housekeeping, and meal preparation for six residents during his work hours.
-He wiped up spills in the kitchen as they occurred.
-He had not been instructed to do deep cleaning of the kitchen.
-He had not cleaned the oven.

Interview with the Administrator at 5:00pm on 7/13/16 revealed:

- kitchen cabinets and drawers will be cleaned and repaired as needed 9/31/16
- knobs will be replaced
- oven will be cleaned 9/31/16
- administrator will monitor for cleanliness of building by doing a weekly inspection and address issues/concerns accordingly 9/31/16

PRINTED: 07/28/2016
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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 076	Continued From page 3 -She was aware there were areas of repair to address. She would like to repaint and repair the facility's interior. -She had tried to get repairs made, but was having difficulty getting the fiduciary of the estate which owned the building and license to provide funds for repairs/maintenance. -The facility had a maintenance person who took care of several buildings owned by the licensee. -She did not have a deep cleaning schedule. None of the residents had complained to her about the facility's condition.	C 076		
C 079	10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (6) have supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This rule apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide towels for residents' use in the facility bathrooms. The findings are: Observation on 7/13/16 from 12:30 - 2:30pm revealed: -Three of four bathrooms used by residents did not have any soap, paper towels or hand towels at that time.	C 079	- each bathroom will have adequate soap and paper towels at all times 9/30/16	

Division of Health Service Regulation

PRINTED: 07/28/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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 079	Continued From page 4	C 079		

-The "guest" lavatory off the living room did not contain any soap or towels.
-The first shared bathroom on the left side of the resident hallway had no soap or towels; one threadbare, used orange and yellow washcloth with several holes in it was hanging on the towel rack.

Confidential interviews with three residents revealed:
-Sometimes there were paper towels available. In the past, some residents had placed paper towels in the toilet, causing plumbing problems.
-The facility provided clean bath towels and washcloths "about every other day".
-Residents had no complaints about availability of facility towels and washcloths.
-Residents kept soap in their rooms; one resident stated "My soap disappears when I leave it in the bathroom".
- One resident stated he "used water to wash his hands and then dried them on his clothing", when no soap or towels were available in the bathrooms.

Interview with the Personal Care Assistant at 2:00pm on 7/13/16 revealed:
-Residents were given fresh towels and washcloths on assigned "bath days" or on request.
-Soap was available to residents on request.

Interview with the Administrator at 5:30pm on 7/13/16 revealed:
-"It has been a while" since towels have been replaced.
-She planned to purge worn towels and restock the facility supply of cloth towels.
-Soap and towels were always available to residents from facility staff.

- towels and soap will be placed in all bathrooms 8/30/16
- Washcloths and towels will be purchased and replaced 8/30/16

Administrator/DIC will monitor bathrooms for soap and paper towels to ensure use and need for washcloths and towels and replace as needed - will do weekly walkthrough to ensure 8/30/16

Division of Health Service Regulation

PRINTED: 07/28/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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 112	10A NCAC 13G .0318(a) Outside Premises 10A NCAC 13G .0318 Outside Premises (a) The outside grounds of new and existing family care homes shall be maintained in a clean and safe condition. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure the outside grounds of the facility were maintained in a clean and safe condition by not removing an old generator from the premises and failing to control fire ants in the yard. The findings are: Observation on 7/13/15 at 4:30pm of the outside premises revealed: -An old, large facility generator was lying at the property edge of the back yard; it was approximately 20 feet west of the new generator. The generator was rusting, and sharp metal edges were exposed. One large fire ant hill was in the left side of the facility backyard, and another fire ant hill was located in the left side yard of the facility. Interview on 7/13/16 with the Administrator at 5:00pm revealed: -The old generator was replaced last year. -Several people had offered to haul it away from the facility. -She was not authorized to allow anyone to take it away from the property. -She did not think it was a hazard to residents, as residents rarely used the backyard. -She stated the maintenance person kept the weeds and grass surrounding the generator trimmed. -She would contact the executor of the estate	C 112	- generator will be removed from facility - fire ant hill will be treated Administrator will inspect outside premises weekly. Staff instructed to notify Admin LJTC of any new fire ant hills	8/30/16 8/30/16 8/30/16

Division of Health Service Regulation

PRINTED: 07/28/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING ___ _____	07/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

(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 112	Continued From page 6	C 112		

(owner and licensee of the facility) to arrange for its removal.
-She had not noticed the fire ant hills.
-No staff or residents had told her there were fire ants in the yard.
-The facility had a contract with an exterminator for fire ant elimination.
-The exterminator had last serviced the facility 2 months ago.
-She will call the exterminator tomorrow to arrange for fire ant extermination.