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PINEWOOD MANOR	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

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{D 000}	Initial Comments The Adult Care Licensure Section and the Hertford County Department of Social Services conducted a follow-up survey on August 23 through August 25, 2017 and August 28 through August 29, 2017 with an exit conference via telephone on August 30, 2017.	{D 000}		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair for 14 of 15 occupied residents' rooms, 4 shared residents' bathrooms, 2 of 2 common hall shower rooms, dining room, and the hallway floor on the A Hall; to assure the walls, ceilings, and floors of the residents' phone room and common living room were kept clean and in good repair; to assure the hallway floor in the Special Care Unit (SCU), the floors, walls, and wall mouldings of 2 of 2 common hall shower rooms in the SCU, and the floors, walls, and baseboards in 3 of 10 residents' rooms and bathrooms in the SCU, and the dining room in the SCU; to assure the hallway baseboards and 12 ceiling air vents on the C Hall; to assure the floors, grout, and walls in the 2 of 2 common hall shower rooms on the C Hall; 9 of 10	D 074		

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occupied residents' rooms on the C Hall, blown lights on the C Hall and front porch for C Hall, and the dining room on the C Hall.

The findings are:

Observation of the shared bathresident roombetween resident rooms #1 and #2 on the A Hall on 8/23/17 at 12:40pm revealed:
-A brown rim around the front base of the toilet.
-A brown line around the perimeter of the tub.

Observation of resident resident room #2 on 8/23/17on the A Hall at 1:05pm revealed there was duct tape the left of the window air conditioning unit measuring the height of the unit and four inches to the left.

Observation of the common hall shower room on the A Hall on 8/23/17 at 1:07pm revealed:
-There was a vent on the ceiling covered in black smudges.
-There was a five inch area of broken tile on the wall to the left of the door upon entering.

Observation of resident room #4 on 8/23/17 on the A Hall at 1:08pm revealed:
-The vent on the ceiling was covered in condensation.
-There were black smudges on the left side of the vent.
-There was a cluster of brown marks embedded into the floor.

Observation of resident room #3 on 8/23/17 on the A Hall at 1:20pm revealed:
-The grates on the vent on the ceiling were dusty.
-There was an area of white paint around the edges of the vent on the ceiling.

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Observation of the shared bathroom between resident rooms #3 and #4 on the A Hall on 8/23/17 at 1:23pm revealed:
-A brown rim around the base of the toilet.
-A rust stain on the tub wall extending from the stopper to the drain.
-The tub drain was rusted.

Observation of resident room #5 on the A Hall on 8/23/17 at 1:29pm revealed:
-The vent on the ceiling was covered in condensation.
-The vent was covered in dark smudges.

Observation of the shared bathroom between resident rooms #9 & #10 on A Hall on 8/23/17 at 1:43pm revealed:
-A brown rim around the base of the tub.
-The sink was lower on the left side of the wall.
-The smoke detector was covered in brown spots.

Observation of resident resident room #6 on the A Hall on 8/23/17 at 1:46pm revealed:
-A two inch area of chipped paint on the edge of the vent on the ceiling.
-A two foot area of the wall where the baseboard was unattached.

Interview with a housekeeper on 8/28/17 at 11:50am revealed:
-She had noticed the vents leaking on the A hall about a month or so ago.
-She notified the Housekeeping Director.
-The Housekeeping Director cleaned the smoke detectors.
-Smoke detectors were last cleaned a few weeks ago.

Interview with the Housekeeping Director on

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8/24/17 at 10:05am revealed:
-He did more housekeeping work than maintenance.
-He planned to wipe down the vents covered in condensation.
-This problem had been going on for years and happens every summer.
-He believed it was caused by the male residents frequently going outside to smoke and allowing hot air to come into the facility.
-He only noticed this being an issue when it was really hot outside.
-He was aware that there were other rooms with vents that leaked,

Interview with the Administrator on 8/24/17 at 10:07am revealed:
-She was aware of the vent leaking in resident room #4 on the A Hall.
-There were also several other rooms with leaking vents.
-She had asked the Housekeeping Director to look into the issue.
-She planned to call the heating, venting, and air conditioning company to assess the issue.
-She would move residents' beds positioned under the vents to ensure they were not affected.

Interview with a resident on 8/29/17 at 5:11pm revealed:
-The tile in the dining room was removed about a month ago.
-There were outside workers working on the floor but they had not been back in over a week.

Interview with a second resident on 8/29/17 at 5:20pm revealed the tile in the dining room was removed about two weeks ago.

Interview with a third resident on 8/29/17 at

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D 074	Continued From page 4 5:24pm revealed: -The dining room tile was removed about a week ago. -The floor looked alright but now it looks nasty. -He did not think the floor should be left as it was. Interview with a fourth resident on 8/29/17 at 5:27pm revealed: -The dining room tile was removed a few weeks ago. -The old tile was coming up and so it had to be removed. -The dining room floor now looked a mess. Observation of the A Hall (men's hall) on 8/23/17 at 12:40pm revealed: -All of the baseboards had been removed on the hall. -The floor at the end of the hall by the door exit door and between the closet and the shared bathroom on the left side of the hall had dried green stains. -The tiles had been removed at the exit door at the end of the hall. -A stack of tiles were by the door at the end of hall. Observation of the floor in the common bathroom at the end of the hall near resident room #18 on 8/23/17 at 12:40pm revealed: -The caulking around the base of the toilet had dried brown stains. -The inside of the tub had black and brown stains. -The area of the floor on the side of the tub had brown and orange stains. -The area of the floor under the green chair had gray and orange stains. -A tile on the wall between the tub and the green chair was broken. -The white cabinets under the sink had built up brown dirt on the top and front of the cabinets.	D 074		

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D 074	Continued From page 5 Observation of resident room #18 on 8/23/17 at 12:43pm revealed: -The light switch on the wall had rust and peeled paint. -The entrance door seal had peeled paint and rust on all three sides. -The lower corner of the wall by the chester was dented and the baseboard was loosed. -The area of the floor in front of the closet and in front of the window had rust stains. -The area of the floor on the right side of the green vinyl chair had gray stains. -The area of the floor between the bed and nightstand had gray and rust stains. Observation of resident room #15 on 8/23/17 at 12:44pm revealed. -The light switch on the wall had peeled paint, rust and gray stains. -One of three sides of the door post had rust. Observation of resident room #16 on 8/23/17 at 1:05pm revealed: -The entrance door post had peeled paint on all three sides. -The wood between the wall and the ceiling had dark brown stains on one of three sides. Interview with a resident who lived on resident room #16 on 8/23/17 at 1:05pm revealed: -Housekeeping mopped, swept and cleaned the rooms daily. -Housekeeping cleaned the bathrooms daily. Observation of resident room #13 on 8/23/17 at 1:23pm revealed the floor had light brown stains throughout the room. An attempted interview with a resident, who lived	D 074		

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D 074	Continued From page 6 in resident room #13, on 8/25/17 at 2:15pm revealed the resident did not want to be interviewed. Observation of the floor in the shared bathroom between resident room #13 and room #14 revealed the caulking around the toilet the base of the toilet was stained a dark brown. Observation of resident room #8 on 8/23/17 at 1:26pm revealed: -There were three of four cracked tiles on the floor at the entrance door . -All four tiles tiles had dark brown stains on one of four sides. -The bottom of the entrance doorpost on one of three sides had peeled paint and rust. -The area of the floor at the entrance to the bathroom had dark gray and brown stains. Observation of the shared bathroom between resident room #7 and room #8 on 8/23/17 at 1:28pm revealed: -The caulking around the base of the toilet was stained dark brown. -The bottom of one of three sides of the door post leading to resident room #8 had multiple rust stains. -The bottom of three of four walls had dark gray stains. Observation of resident room #12 on 8/23/17 at 1:29pm revealed the bottom of one of three door posts at the entrance door had peeled paint and rust. Observation of resident room #7 on 8/23/17 at 1:29pm revealed: -One of three door posts at the entrance door had peeled paint and rust.	D 074		

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-The vent cover on the ceiling had dust and around the vent there were multiple black stains.
-The light switch on the wall had pink stains, peeled paint and rust.
-The area of the wall around the light switch had light brown stains.

Observation of resident room #11 on 8/23/17 at 1:53pm revealed:
-There was a missing tile at the entrance of the door.
-The bottom of two of three door post had rust stains.
-The side of one of three door posts near the door knob had peeled paint.
-There were two broken tiles on the floor at the entrance to the bathroom.
-One of four walls had light and dark brown stains.
-The light switch on the wall at the entrance door had peeled paint and brown and grays stains.

Observation of the ceiling on A Hall living room on 8/23/17 at 2:04pm revealed:
-Three of three vent covers had light brown stains.
-The "popcorn" ceiling's drywall was loosed from the ceiling.

Observation of two dining rooms on A Hall on 8/23/17 at 2:12pm revealed:
-All of the baseboards on the floor had been removed on all four walls in both dining rooms.
-Three fourth of the tile was missing in the the dining room (A) closest to the kitchen.
-The cream tile in dining room A had gray and dark brown stains.
-There were several broken tiles in dining room A.
-The cream tile in the second dining room (B), which attached to dining room A, had brown and

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D 074	Continued From page 8 gray stains. Observation of the floor in the resident phone room revealed the tiles had dark gray and brown stains. Interview with the Cook on 8/28/17 at 4:50pm revealed dietary staff swept and mopped the dining room on A Hall every night before they left for the day and as needed between meals. Confidential interview with revealed: -The wall and the light switch have had stains and peeling paint since the resident had been living at the facility. -Housekeeping cleaned the floors daily. -Housekeeping don't clean the walls and they don't dust the light fixtures. -The baseboards were removed when staff put the new tile on the floors, which was two weeks ago. Interview with the Housekeeping Supervisor on 8/24/17 at 10:50am revealed: -The air vents on the ceiling were cleaned monthly. -He was aware of the cracked tile in the facility. -He was waiting on the baseboards to come in so he could replace them on the men's hall. -He had replaced some of the light switches, but he had not replaced them all. Interview with the maintenance person on 8/24/17 at 10:50am revealed: -He was not aware of the loosed drywall in the living room on A Hall. -If the drywall was loosed, there was probably a leak in the ceiling. -He would check on it.	D 074		

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D 074	Continued From page 9 Interview with a Medication Aide (MA) on 8/25/17 at 1:34pm -Housekeeping cleaned, swept, mopped, cleaned vents and wiped walls daily. -On A Hall, dietary staff mopped and swept the dining room after each meal. -Dietary staff cleaned the walls in the kitchen as needed. -No residents complained of the cleanliness of the facility and the dining room. Observation of the Special Care Unit (SCU) on 8/23/17 between 11:50am-1:30pm revealed: -Several brown stains were seen along the floor throughout the hallway. -A sticky clear substance was covering the entire hallway floor. Observation of residents' room #3 on 08/23/17 at 12:00pm on the SCU revealed the window blind was broken and 2 slats were missing. Observation of a SCU common hall shower room on 8/23/17 at 12:30pm revealed: -The floor tiles in the shower near the drain were discolored by a dark brown stain. -The tiles and molding surrounding the exterior base of the shower had several brown dirt stains along the base of the shower. -The grout and caulk on the left shower wall were missing. -Approximately 3 tiles were missing from the left wall inside of the shower stall. -The floor of the tub was stained with numerous brown spots. -The two water supply lines were rusted from the wall to the toilet. -The floor surrounding the toilet was discolored with a brown stain. -All of the wall moldings had a dark brown buildup.	D 074		

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D 074	Continued From page 10 Observation of a SCU common hall shower room on 8/23/2017 at 12:45pm revealed: -The light fixture was dirty with a brown film. -The legs and handrails of a raised toilet seat were covered with rust stains. -The floor surrounding the toilet was discolored by a brown stain approximately 2 inches in circumference. -The drain of the shower floor was discolored with a brown stain. -All of the wall moldings had a dark brown buildup. Observation of the shared bathroom for residents' rooms #9 and #10 in the SCU on 8/23/17 at 1:00pm revealed: -The bathroom floor was covered with a clear sticky substance. -The sink was dirty with brown stains. -All of the wall moldings were covered with brown dirt build up. Observation of resident's room #3 in the SCU on 8/23/2017 at 1:10pm revealed: -Four of four baseboards had black dirt buildup. -The entire window pane was cloudy with brown smears. -Several brown spots were scattered across the floor. -Thick brown dust buildup was on both dressers in the room Observation of resident's room #5 in the SCU on 8/23/2017 at 1:20pm revealed: -Four of four baseboards had black dirt buildup. -The entire window pane was cloudy with a brown dirt buildup. Interview with housekeeping supervisor on	D 074		

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D 074	Continued From page 11 8/24/2017 at 1:30pm revealed: -He and one other housekeeper were responsible to clean the entire facility. -There was no housekeeping staff in the facility after the 1st shift (7am-3pm) -It was not routine for the housekeeping supervisor to do facility walk through to assure that the facility was properly cleaned. -He "may do a walk through of the facility about once a week". -The baseboards were cleaned monthly throughout the facility -Floors were swept and mopped twice a day throughout the facility and all furniture was dusted daily. -Housekeeping staff signed off on the facility cleaning checklist daily when cleaning tasks were completed. Review of the facility housekeeping checklists on 8/24/17 on revealed: -Daily cleaning included cleaning all bathrooms, bedroom floors, dusting underneath all beds, cleaning all hallways, the employee lounge, front door windows, laundry room floors, laundry room door knobs, exit door knobs, vacuuming the front lobby, and dust front lobby areas 2 times a week. -Monday cleaning schedule included cleaning of the nursing, business, activity, and adminstrator's offices; cleaning the left side of C Hall by sanitizing mattresses, box springs, bathroom, bedroom, and closet door handles,dusting headboards and dressers, cleaning blinds and baseboards, clean behind doors. -Tuesday cleaning schedule included cleaning the right side of C Hall by sanitizing mattresses, box springs, bathroom, bedroom, and closet door handles,dusting headboards and dressers, cleaning blinds and baseboards, clean behind doors.	D 074		

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-Wednesday cleaning schedule included cleaning the left side of B Hall by sanitizing mattresses, box springs, bathroom, bedroom, and closet door handles,dusting headboards and dressers, cleaning blinds and baseboards, clean behind doors.
-Thursday cleaning schedule included cleaning the rightside of B Hall by sanitizing mattresses, box springs, bathroom, bedroom, and closet door handles,dusting headboards and dressers, cleaning blinds and baseboards, clean behind doors.
-Friday cleaning schedule included cleaning the left side of the Special Care Unit hallway by sanitizing mattresses, box springs, bathroom, bedroom, and closet door handles,dusting headboards and dressers, cleaning blinds and baseboards, clean behind doors.
-Saturday cleaning schedule included cleaning the right side of the Special Care Unit hallway by sanitizing mattresses, box springs, bathroom, bedroom, and closet door handles,dusting headboards and dressers, cleaning blinds and baseboards, clean behind doors.
-Sunday cleaning schedule included, along with the bedrooms and bathrooms, cleaning the smoke room, cleaning the main sitting room and C Hall sitting room, clean hallway pictures and baseboards, laundry rooms, vending machines, and sanitizing all door knobs.
-The cleaning checklist was to be initialed daily when cleaning tasks were completed by the housekeeping staff.
-No cleaning tasks were documented as completed on 6/23/17, 7/3/17, and 7/4/17.
-No cleaning tasks were documented as completed from 7/8/17 through 8/24/17.

Observation of the C Hall on 8/23/2017 between 12:00pm-2:10pm revealed several black and

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D 074	Continued From page 13 brown stains were seen along all the baseboards throughout the hallway. Observation of the living room on the C Hall on 8/23/17 at 12:05pm revealed: -Several black stains were scattered on the carpet. -Torn pieces of tan and white paper were scattered across the carpet. -The two ceiling air vents next to the door entrance were covered with brown dust. Observation of the common hall shower room on the C Hall between residents' room #12 and #13 on 8/23/17 at 12:10pm revealed: -The paint was chipped along the lower side of the door frame entrance. -The showerhead was continuously dripping water. -There was a white shower mat with several brown stains on the floor in front of the shower stall. -The grout and caulking on the shower walls was discolored with brown and black stains. -The lower wall between the door entrance and shower stall had a chipped, flaking white paint area that measured approximately 6 inches long and 1 inch wide. -The perimeter of the ceiling air vent by the bathroom window had several black and gray spots. Observation of the shared bathroom on the C Hall between residents' rooms #8 and #7 on 8/23/17 at 12:20pm revealed: -There was a hole in the shared door leading into residents' room #7 that measures approximately 2 inches long by 2 inches wide. -There were several scraped marks along the bottom of the bathroom door leading into	D 074		

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residents' room #7.
-The shared bathroom door leading into residents' room #8 had several black and brown scraped marks that exposed the underlying wood.
-Two scraped paint areas next to the bathroom sink that measured approximately 1 inch wide and 3 inches long.
-Numerous brown spots and peeling paint surrounding the perimeter of the light switch.

Observation of residents' room #8 on the C Hall on 8/23/17 at 12:25pm revealed:
-The frame of the ceiling air vent next to the window was covered with black spots.
-An area of approximately 2 feet of brown dust was caked on the ceiling between the ceiling air vent by the window and the smoke detector.
-The vents of the ceiling air vent next to the room entrance was covered with brown dust.
-Several brown spots and scrape marks were on the floor to the right of the door entrance that covered an area approximately 2 feet long and 6 inches wide.

Observation of residents' room #14 on the C Hall on 8/23/17 at 12:30pm revealed:
-The frame of the ceiling air vent next to the window was covered with black and gray spots.
-The paint was peeling around the perimeter of the ceiling air vent next to the window on 3 of 4 sides.
-Brown dust was caked on the ceiling between the ceiling air vent by the window and the smoke detector.
-The paint was peeling around the perimeter of the light fixture in the middle of the ceiling.

Interview with a resident in residents' room #14 on the C Hall on 8/23/17 at 12:30pm revealed:
-She had not reported any problems with the

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peeling paint or the dust on the ceiling air vents or ceiling.
-Someone had come and looked at the air vents and ceilings in her room about 2 weeks ago.
-She could not to remember who came to her rooms 2 weeks ago.
-Staff did not clean the air vents.
-The floor in her room was swept and mopped by housekeeping every day.

Observation of residents' room #6 on the C Hall on 8/23/17 at 12:40pm revealed:
-The paint was chipped and peeling around the perimeter of the ceiling air vent next to the door entrance and formed a lip around the frame of the vent that measured about 8 inches long and the peeling paint hung approximately 1 and ½ inches down from the ceiling.
-Brown dust was on the slat of the ceiling air vent next to the entrance of the door.
-The ceiling air vent next to the window and the perimeter surrounding the air vent were covered with black and gray spots.
-Dark gray dust was caked on the ceiling between the ceiling air vent by the window and the smoke detector that covered an area approximately 18 inches long and 1 foot wide.
-The paint on the door frame of the first closet was had chipped and scraped areas that measured approximately 2 feet long and approximately 2 inches wide and exposed the green paint underneath.

Observation of the shared bathroom on the C Hall between residents' room #5 and #6 on 8/23/17 at 12:45pm revealed:
-Several rust spots were on the wall around the light fixture over the sink.
-The towel rack was missing on the right side of the sink with 4 open nail holes.

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D 074	Continued From page 16 -The paint was cracked and chipped around the perimeter of the sink. -Both interior shared bathroom doors had several scraped marks across bottom thirds of the doors. Observation of residents' room #6 on the C Hall on 8/23/17 at 12:50pm revealed: -The paint was chipped and peeling around the perimeter of the ceiling air vent next to the door entrance and hung down from the vent. -The slats of the ceiling air vent was covered with thick brown dust. -A black scraped mark was midway of the wall area next to the entrance of the shared bathroom that measured approximately 8 inches long. Observation of residents' room #4 on the C Hall on 8/23/17 at 12:50pm revealed: -Duct tape was covering the vents of the ceiling air vent next to the window. -Brown dust on the smoke detector and the ceiling areas surrounding the smoke detector. -A small sponge mop was behind the door of the room. Interview with a resident in residents' room #4 on C Hall on 8/23/17 at 12:53pm revealed: -She had put the duct tape on the vent to keep the cool air from blowing. -She would get the housekeeping supervisor to remove it for her. -She had not noticed the dust on the smoke detector or the ceiling. -She did most of the cleaning in her room so housekeeping did not have to do much cleaning in her room. -She did not like the way housekeeping cleaned her room. -Staff mainly cleaned her bathroom every day.	D 074		

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D 074	Continued From page 17 Observation of the shared bathroom on the C Hall between residents' room #3 and #4 on 8/23/17 at 12:57pm revealed: -Two of four walls had scattered black and brown stains. -The sink was stained with brown spots and brown residue. -Blue soap film was melted all over the sink faucet. Observation of residents' room #15 on the C Hall on 8/23/17 at 1:00pm revealed: -The ceiling around the air vent next to the door entrance had peeling paint and brown dust to the air vent slats. -The ceiling area around the light fixture had a crack on the right side of the light fixture that measure 4 inches long. -The ceiling air vent next to the window had several black and gray spots with water droplets condensed on its frame. Observation of the shared bathroom on the C Hall between residents' room #15 and #16 on 8/23/17 at 1:10pm revealed: -Three of four walls had numerous black and brown stains with exposed green paint from several scraped marks on the walls. -Several rust spots were around the light fixture in the bathroom. -A four inch length of baseboard was missing from the wall on the right side of the toilet. Observation of residents' room #16 on the C Hall on 8/23/17 at 1:25pm revealed: -The paint was chipped and peeling around the ceiling air vent next to the door entrance. -The wall area adjacent to the door entrance had several brown spots that were scattered on the wall.	D 074		

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D 074	Continued From page 18 -The second closet door had 2 scarred areas that measured 1 foot wide and 8 inches wide. Observation of residents' room #2 on the C Hall on 8/23/17 at 1:30pm revealed: -The paint was peeling around the ceiling air vent next to the door entrance and the slats of the vent were covered with brown dust. -The paint was peeling around the light fixture in the room. -Several areas of the floor in the room had scattered brown stains and a gray film on it. Interview with a resident in residents' room #2 on the C Hall on 8/23/17 at 1:30pm revealed: -She complained that the lightbulb in the hallway light fixture in front of her room and the lightbulb on the front porch of the C Hall had been burned out for several weeks and that she reported to the housekeeping supervisor 4 times. -She was afraid to go out on the front porch in the evenings and the early mornings to smoke because it was too dark and she couldn't see in the dark. -She had told the housekeeping supervisor about the blown lightbulb last on the morning of 8/23/17. -She complained to the maintenance person too, but he doesn't change the blown lightbulbs in the facility. Observation of the hallway area outside of residents' room #2 on the C Hall on 8/23/17 at 1:30pm revealed: -There were two ceiling light fixtures in the hallway approximately 8 feet apart. -The light fixture in front of residents' room #2 did not work even though the light switch was turned on. -The lighting was dim in front of the residents' room #2.	D 074		

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D 074	Continued From page 19 -The other ceiling light fixture was lit and worked properly. Observation of the front porch of the C Hall on 8/23/17 at 1:35pm revealed: -There was only one light fixture for the porch area. -The light did not work when the light switch was turned on. -There was no other source of lighting for the front porch. Observation of the shared bathroom on the C Hall between residents' room #1 and #2 on 8/23/17 at 1:40pm revealed: -The vinyl floor tiles around the toilet were peeling away from the floor base. -The paint was cracked around the entire perimeter of the bathroom sink. Observation of residents' room #1 on the C Hall on 8/23/17 at 1:50pm revealed: -Several areas of the floor in the room had scattered brown stains and gray film on it. -Brown dust covered the slats of the ceiling air vent next to the window. Observation of the common shower room on the C Hall across from residents' room #6 on 8/23/17 at 2:10pm revealed: -The outside wooden walls of the whirlpool had gray dust and several black and brown spots. -The baseboard on the right side of the whirlpool was partially detached from the whirlpool area approximately 3 inches. -Gray dust was on the ceiling around the air vent next to the window. Observation of the dining room on C Hall on 8/24/17 at 11:30am revealed there were several	D 074		

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D 074	Continued From page 20 black and brown stains on the floor with numerous rust spots around the wall perimeter. Interview with the housekeeping supervisor on 8/24/17 at 10:54am revealed: -He and one other housekeeper were responsible to clean the entire facility every day. -There was a second housekeeper who had left a couple of weeks ago. -All of floors were swept and mopped every day in the facility. -He saw the stains on the carpet in the living room on the C Hall a couple of weeks ago but he was not sure if he told the Administrator about the stains. -The baseboards were cleaned once a month throughout the facility. -The walls were cleaned about once a week and he last cleaned the walls in the facility on 8/23/17. -The walls and shower stalls in the common hall bathrooms were cleaned every day. -He was responsible for cleaning the ceiling areas and air vents about once or twice a month or whenever he saw it needed cleaning. -He had not noticed any problems with the any ceiling vents being dirty or any dust on the ceiling. -A resident had complained about a lightbulb not working on the C Hall and the outside light on the front porch of the C Hall. -He had forgotten to change the lightbulbs. -The housekeeping staff was not responsible to clean bedside commodes. -The personal care aides were supposed to clean the bedside commodes after the residents used them. -He did not know anything about the shower mat in the common hall shower room on the C Hall. -Scraped doors and holes in doors were the responsibility of the maintenance staff to fix. -He reported if anything needed to be fixed to the	D 074		

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Administrator or to the maintenance staff.

Interview with a housekeeper on 8/28/17 at 11:40am revealed:
-She had been a housekeeper at the facility for 7 months.
-She and the housekeeping supervisor were responsible for all the cleaning in the facility.
-There was a third housekeeper for the facility but the housekeeper left about 2 weeks ago.
-She worked from 7:00am to 3:00pm with alternating weekends.
-She cleaned all the baseboards in the facility every other day with a bleach and water mixture.
-She swept and mopped all of the floors in the facility every day.
-She noticed the stains on the carpet in the living room on the C Hall a week ago and she tried to clean the stains.
-She could not get the stains out of the carpet.
-She did not report the carpet stains to the housekeeping supervisor or the Administrator.
-She cleaned all the walls and shower walls every day.
-She did not clean the air vents or the ceiling areas in the facility.
-The housekeeping supervisor usually cleaned the air vents and ceiling areas.
-The housekeeping supervisor last cleaned the air vents a couple of weeks ago.
-She could not be specific when the housekeeping supervisor cleaned the air vents.
-She was not sure how often the housekeeping supervisor cleaned the air vents.

Second review of the facility housekeeping checklists on 8/25/17 on revealed:
-No cleaning tasks were documented as completed on 6/23/17, 7/3/17, and 7/4/17.
-All cleaning tasks were documented as

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D 074	Continued From page 22 completed from 7/8/17 through 8/25/17. -Cleaning tasks were pre-documented as completed for 8/26/17 and 8/28/17.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations and interviews, the facility failed to assure that 2 of 3 halls were free of unpleasant and offensive odors that spread through the entire Special Care Unit, the A Hall, the front sitting room, and dining room areas. The findings are: Observations of the Special Care Unit (SCU) during the facility tour on 8/23/17 from 11:30am - 12:55pm revealed: -There was a strong foul odor upon entering the SCU that extended throughout the entire hallway. -Nine of nine resident rooms smelled strongly of urine. Observation of the SCU on 8/24/2017 at 9:00am revealed the entire SCU smelled strongly of urine.	D 075		

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D 075	Continued From page 23 Observation of SCU on 8/25/17 at 9:00am revealed the strong smell of urine odor in combination with a cleaning solution were prominent throughout the unit. Observation of resident room #10 and the shared bathroom between resident' room #9 and #10 on the SCU on 8/24/2017 at 9:05am revealed the residents' rooms and shared bathroom smelled strongly of urine. Interview with the Special Care Coordinator (SCC) on 8/25/17 at 2:00pm revealed: -The SCU always had a strong urine odor. -The urine odor can be smelled as soon as you come into the SCU. -She did not know what caused the strong urine odor. -She mopped all of the floors in the residents' rooms and the common hall bathrooms once a day to keep the odor down. -It bothered her to work with such a strong urine odor. -She did not recall if she had ever complained about the strong urine smell to the Administrator, housekeeping staff, or maintenance staff. Interview with a resident in the SCU on 8/25/17 at 8:00am revealed: -The SCU always smelled badly. -The resident did not know where the urine odors came from. Interview with a resident on 8/23/17 at 12:50 pm revealed: -The resident preferred not to eat the food at the facility -He did not eat in the dining room because certain residents smelled of urine.	D 075		

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D 075	Continued From page 24 -He believed certain residents were smelly. -There was an urine odor from the common hall shower room. -The urine odor ould also be smelled in the dining room for the A Hall. Confidential interview with a second resident on 8/25/17 at 4:07pm revealed: -The facility always smelled of urine. -He had not complained about the smell to anyone. Observation of the A Hall dining room, living room and A Hall during the tour on 8/23/17 from 12:22pm to 12:29pm revealed there was a strong urine odor. Observation of resident room #17 on 8/23/17 at 12:45pm revealed the room had a mild odor of feces. An attempted interview with a resident, who lived in Room #17, on 8/23/17 at 12:45pm revealed the resident was not interviewable. Observation of resident room #13 on 8/23/17 at 1:20 pm and on 8/25/17 at 1:30pm revealed the room smelled like urine. An attempted interview with a resident, who lived in Room #13 on 8/25/17 at 2:15pm revealed the resident did not want to be interviewed. Observation on 8/24/17 at 7:55am upon entrance into the facility and the living room revealed a strong urine smell. Interview with a Medication Aide on 8/25/17 at 1:36pm revealed: -All of the residents complained of the odor on A hall.	D 075		

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-There were two residents who lived on the hall, who caused the odor due to their refusal of personal care.

Interview with a Cook on 8/28/17 at 4:50pm revealed:
-The A hall dining room and the living room had an odor because there were two male residents who refused personal care.
-The residents complained of the smell.
-When the residents complained, she did not do anything.

Interview with a Personal Care Aide on 8/28/17 at 1:18pm revealed:
-The men's hall had been smelling like urine since she had been working at the facility (5 years).
-The smell had gotten better since they had replaced floor tile on the men's hall (within the past couple of months).
-When residents complained of the odor on the men's hall, she told the housekeeper.

Review of Resident Council Meeting notes dated 8/25/17 revealed a resident complained about body odors from a resident who lived on the A Hall.

Interview with a housekeeper on 8/28/17 at 11:40am revealed:
-She had been working at the facility for about 7 months as a housekeeper.
-She had noticed that the A Hall had problems with "bad" odors.
-The odors on the A Hall were so bad because there were residents who refused to bathe who consistently urinated on the floors.
-The odors on the A Hall had gotten better over the last 3 or 4 months because the housekeeping

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D 075	Continued From page 26 staff had been mopping more often. -She did not know about any complaints of urine odors in the SCU when she worked in the SCU. Interview with the Administrator on 8/29/17 at 1:30pm revealed: -She and the staff had been working to manage the odors in the facility. -Housekeeping staff mopped all the floors in the facility every day and they mopped more frequently in those residents' rooms who were incontinent. -Floor tiles had been already been replaced in the Room #14 on the A Hall. -It was expected for the facility to have some odors because of the population that lived in the facility. -She knew there were two male residents on the A Hall regularly refused to bathe or change their clothes. -Staff maybe able to bribe these male residents to bathe and change their clothes about once a week. -Staff couldn't force the male residents to bathe if the residents refused. -She did not know what else the staff could do to keep down the odors. The facility failed to assure that 2 of 3 halls (A Hall and Special Care Unit) were free of unpleasant and offensive odors that spread through the entire Special Care Unit, the entire A Hall, and dining room area for the A Hall. This failure resulted residents being subjected to strong and offensive odors within the facility. This failure was detrimental to the welfare of the residents and constitutes a Type B Violation. Review of a Plan of Protection dated 8/29/17 revealed:	D 075		

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D 075	Continued From page 27 -All staff will immediately check residents' rooms and closets and trash cans for soiled items. -Housekeeping staff will follow-up with cleaning the A Hall and the Special Care Unit today and as scheduled daily and monitor on off times. -The facility housekeeping staff will clean accordingly as scheduled daily. -All staff will observe daily for any items that cause unpleasnt odors and destroy those items immediately to eliminate odors. -The Administrator, Resident Care Coordinator, and Special Care Coordinator will monitor the facility daily and as needed for odors.	D 075		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure all furnishings were in good repair including 2 chairs, 6 dressers, and 5 nightstands in the residents' rooms on the A Hall; 4 nightstands, 2 chairs, and a bed in the Special Care Unit; 4 chairs, 3 chest of drawers, 3 mattresses, and 2 headboards on the C Hall, and 9 tables and 13 chairs in the dining room on the C Hall. The findings are: Observation of resident room #5 on the A Hall on 8/23/17 at 1:27 pm revealed:	D 076		

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D 076	Continued From page 28 -There was a chair with torn leather on the arms and seat. -The seat of the chair had a large sunken area in the middle of the padding. -The large dresser in the room was missing a handle on the left side of the third drawer. -The nightstand was missing a handle on the top drawer. Observation of resident room #6 on the A Hall on 8/23/17 at 1:46 pm revealed there was a chair with a large sunken area in the seat of the chair. Observation of resident room #18 on 8/23/17 at 12:43pm revealed a knob was missing off of the chester drawer. Observation of resident room #15 on 8/23/17 at 12:44pm revealed. -The wooden night stand by the bed closest to the window had scratched wood on the top of the right side and front of the nightstand and on top of the first drawer. -The top of the wooden chester, the front of all four chester drawers and the bottom of the chester had scraped wood. Observation of resident room #14 on 8/23/17 at 12:59pm revealed: -Two of four wooden chester drawers had pieces of white paper stuck on the drawers -All four chester drawers had scraped wood. -The top of the wooden nightstand by the chester was stained a lighter brown and had two areas of dried white paper stuck to it. -Both nightstand drawers and both sides of the nightstand had scraped pieces of the wood. -There was a white unknown substance around the keylatch on the second drawer. -The bottom of the second drawer on the nightstand had light brown paper stuck to it.	D 076		

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D 076	Continued From page 29 Observation of resident room #16 on 8/23/17 at 1:05pm revealed: -All four wooden chester drawers had scraped wood -The top chester drawer had and a black stain in the middle of the drawer. Observation of resident room #13 on 8/23/17 at 1:23pm revealed: -The top and the sides of the wooden nightstand, the front of both drawers and the area between the drawers had scraped wood. -The top of the nightstand had several pieces of white paper. -The top and both sides of the wooden chester and all four drawers had scraped wood. -The top of the wooden dresser had white paper stuck to it. -One of six dresser drawers had three knobs missing. -The top and front of drawers of a second nightstand near the entrance door had scraped wood. Observation of resident room #8 on 8/23/17 at 1:26pm revealed three of eight handles on four chester drawers had a white unknown substance. Observation of resident room #7 on 8/23/17 at 1:29pm revealed: -The top of the wooden chester near the closet and the front of three of four chester drawers had scraped wood. -The wooden nightstand between the two beds had scraped wood on top of the nightstand and the bottom shelf. Interview with a resident who lived in resident room #7 on 8/23/17 at 1:29pm revealed:	D 076		

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D 076	Continued From page 30 -The chester and the nightstand had scraped wood every since the resident had been living at the facility. -The resident had been living at the facility for two weeks. Based on record review and interviews, the above resident had been living at the facility for over one year. Observation of resident room #11 on 8/23/17 at 1:53pm revealed the top of the wooden chester had several areas of white paper stuck to the chester. Interview with a Medication Aide (MA) on 8/25/17 at 1:34pm -Housekeeping dust the furniture daily. -The residents had not complained about the furniture at the facility. Observation of residents' room P3 in the Special Care Unit (SCU) on 8/23/2017 at 12:30pm revealed: -The night stand had 2 missing handles on the top drawer. -The dresser had 2 missing handles on the first two drawers. Observation of Room P10 in the SCU on 8/23/17 at 12:35pm revealed: -The night stand closest to the door was missing a knob on the top drawer. -The night stand by the window was missing a knob on the bottom drawer Observation of residents' room P4 in the SCU on 8/23/17 at 12:40pm revealed: -The bed next to the door was tilted on its left side at the foot of the bed. -The night stand was missing 2 handles on both	D 076		

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D 076	Continued From page 31 the top and bottom drawers Observation of the living room in the SCU on 8/23/2017 at 12:25pm revealed two vinyl chairs had numerous scarring and scratches on all of their wooden legs. Interview with housekeeping supervisor on 8/24/2017 at 1:30pm revealed: -Any problems with the furniture or any needed furniture repairs were reported daily to the Administrator. -The Administrator then allowed him to complete a request to purchase any needed items to make repairs to the furniture. -It was a problem with getting handles for the night stands and dresser drawers in the facility because there was only one hardware store locally and they do not always have a supply of the furniture handles. Observation of the living room on the C Hall on 8/23/17 at 12:05pm revealed: -All 4 wooden legs of a pink vinyl chair were chipped and worn. -The armrests and headrest of a burgundy cloth rocking chair had several brown stains. Observation of residents' room #4 on the C Hall on 8/23/17 at 12:40pm revealed there was a brown 4-drawer chest that had several chipped areas all over it and was covered by brown dust. Observation of residents' room #6 on the C Hall on 8/23/17 at 12:53pm revealed: -There was a brown 4-drawer chest with several chipped areas and worn laminate set next to the entrance of the door. -A pink vinyl chair with numerous cracked areas to the seat cushion had 4 wooden legs that were	D 076		

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D 076	Continued From page 32	D 076		

chipped and scarred.

Observation of residents' room #15 on the C Hall on 8/23/17 at 1:00pm revealed:
-There was a brown 4-drawer chest with several chipped areas and had several large white oval-shaped stains across the top of the chest.
-A green vinyl chair had 4 wooden legs that were chipped and scarred and the left wooden armrest of the chair was chipped and worn.

Observation of residents' room #4 on the C Hall on 8/23/17 at 12:40pm revealed there was a brown 4-drawer chest that had several chipped areas all over it and was covered by brown dust.

Observation of residents' room #16 on the C Hall on 8/23/17 at 1:25pm revealed:
-The mattresses on 2 of 2 beds were visibly concaved in the middle of each mattress.
-The headboard of the bed by the window was broken and had to be pushed against the wall hold the headboard in place.
-There was a brown 4-drawer chest with several chipped areas next to the bathroom door.

Interview with a resident in residents' room #16 on 8/23/17 at 1:25pm revealed:
-The headboard on the bed had been broken for at least 2 months.
-She had reported to the housekeeping supervisor about 2 months ago.
-She had also complained about "the sink in the middle of her mattress" on her bed then too.
-It was not comfortable sleeping on a mattress with "a sink in the middle of it".

Observation of residents' room #2 on the C Hall on 8/23/17 at 1:40pm revealed:
-The headboard of the bed next to the door was

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broken and could be moved back and forth about 3 inches at the top.
-Both 4-drawer chests were chipped and the wood surfaces on the sides and top were worn.
-The medicine cabinet inside of the shared bathroom had rust stains scattered around its perimeter.

Observation of residents' room #1 on the C Hall on 8/23/17 at 1:55pm revealed:
-Both 4-drawer chests were chipped and the wood surfaces on the sides and top were worn.
-A blue gel mattress on the hospital bed next to the window had sunken area in the middle of the mattress that measured approximately 3 feet long and 1 foot wide.
-The crank handle was missing on the foot of the hospital bed.

Interview with a resident in residents' room #1 on the C Hall on 8/23/17 at 1:55pm revealed:
-The chests in the rooms had been scarred up for as long as she could remember.
-She slept in the hospital bed and the mattress was uncomfortable and it was hard to get out of the bed because the bed was too low.
-She complained to the staff every day when they got her up out of bed that the mattress did not feel good.
-She did not know if her hospital bed could be elevated or if her bed had a crank handle to raise the bed up.

Interview with the housekeeping supervisor on 8/24/17 at 10:50am revealed:
-The housekeeping staff cleaned and dusted all of the furniture in the facility every day.
-He had noticed scarred furniture in the residents' rooms and reportd to the Administrator 2 weeks ago.

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D 076	Continued From page 34 -He does a walk-through of the facility every day to check for any problems and reports them to the Administrator when he sees any problems. Observation of the dining room on the C Hall on 8/24/17 at 11:30am revealed: -The white laminated siding was peeling from the outside perimeter and chipped tabletops to 5 of 9 tables -The table support legs were rusty to 8 of the 9 tables. -One of one wooden table had chipped worn wood with black and brown stains to its tabletop. -Three of three wooden chairs were chipped and scarred. -Two of the three wooden chairs had broken chair leg supports and were being used by the residents. -Ten of ten vinyl chairs had several black and brown stains and several rust stains on their metal chair legs. Interview with a medication aide on the C Hall on 8/24/17 at 11:30am revealed: -She had not noticed any problems with the chairs in the C Hall dining room. -She would let the Administrator know about the broken wooden chairs as soon as lunch was over. -She had noticed the laminate that was peeling around the sides of the tables. -The Administrator was working on replacing the furniture in the C Hall dining room but she did not know when the new furniture was coming. -Staff usually reported any problems with furniture to the housekeeping supervisor or the Administrator. Confidential interview with staff revealed: -A lot of the furniture in the facility was old and	D 076		

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needed to be replaced in the residents' rooms.
-The staff person did not know about any complaints from residents about the condition of the furniture in the residents' rooms.
-The Administrator had replaced some of the most worn furniture in the last month.
-It was going to take some time and money to replace all of the furniture that needed to be replaced.
-Staff was supposed to report any broken furniture to either the housekeeping supervisor or the Administrator and remove the broken furniture immediately.
-The staff was not sure if the housekeeping supervisor or the Administrator were aware of the broken chairs in the C Hall dining room.

Interview with the Administrator on 8/24/17 at 4:45pm revealed:
-She was in the process of replacing the worn furniture that was in the facility but it would take time.
-She did not know about the broken furniture in the C Hall dining room.
-She would make sure the broken chairs were removed from the dining room on the C Hall.
-The housekeeping supervisor and staff reported to her if there were any problems with the furniture.
-She was not aware of any problem with residents complaining of their mattresses being uncomfortable or the broken crank on the hospital bed.

Observation of the dining room on the C Hall on 8/25/17 at 7:33am revealed the 3 broken wooden chairs had been removed.

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D 079	Continued From page 36	D 079		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to prevent hazards as evidenced by 12 broken doors, 2 light fixtures, and 2 rusted raised toilets on the SCU; 4 rusted smoke detectors, 12 broken doors, 5 closet doors, 1 bathroom sink, 1 light fixture, 1 vent cover, 3 loose cords, and 1 phone jack with exposed wiring on the A hall; roaches and flies, chipped paint on 2 door frames, 1 rusty scissors, 2 non working light bulbs and 1 bucket and 1 bedside commode with rust stains, 1 stained shower mat, 1 dripping water fixture, 1 door with a hole and 4 chipped, scraped and marked doors on C hall. The findings are: Observation of the Special Care Unit (SCU) on 08/24/17 between 11:50am-1:30pm revealed: -Twelve of twelve doors had scraped marks across the lower halves of the doors. -The wood finish of 10 of 10 bedroom doors were faded on the inside the residents' rooms. -Several flies were seen in the dining area and both common hall shower rooms.	D 079		

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D 079	Continued From page 37 Observation of resident room # 1 on the A Hall on 8/23/17 at 12:41pm revealed the smoke detector in the ceiling was covered in brown rust spots. Observation of resident room #3 on 8/23/17 on the A Hall at 1:20 pm revealed the smoke detector was covered in brown spots. Observation of resident room #5 on the A Hall on 8/23/17 at 1:29 pm revealed the smoke detector was covered in brown spots. Observation of the shared bathroom between resident rooms #9 & #10 on A Hall on 8/23/17 at 1:43 pm revealed the smoke detector was covered in brown spots. `Observation of the last common bathroom on A Hall by resident room #18 on 8/23/17 at 12:40pm revealed: -The bathroom sink was loosed and not fitted correctly on the cabinet. -The cabinet doors were not closed evenly. -There were three bent areas of wood between the sink and the cabinets. -There was a chipped piece of wood on the top of the cabinets. Observation of resident room #18 on 8/23/17 at 12:43pm revealed: -One of two door handles were missing on the closet door. -The two wooden closet doors did not close together evenly. Observation of resident room #14 on 8/23/17 at 12:59pm revealed the outside of the wooden entrance door had scrapes of wood from the top to the bottom of the door. Observation of resident room #16 on 8/23/17 at	D 079		

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D 079	Continued From page 38 1:05pm revealed: -The outside of the wooden entrance door had scraped wood on the middle and bottom of the door. -The two wooden closet doors did not close together evenly. -Each closet door had two areas of white paint. Observation of resident room #13 on 8/23/17 at 1:23pm revealed: -The back of the entrance door above and below the door knob had dark brown stains and light gray stains. -The front of the closet door had dark stains above and below the door handle; there were three light brown paste-like substances above the door knob; there was scraped wood above and below the door knob; there was a dried liquid substance that dripped down by the door knob; and there were several dark brown stain across the bottom of the door. Observation of the shared bathroom between resident room's #13 and room #14 on 8/23/17 at 1:23pm revealed: -The inside of the light fixture on the wall had black stains and the light fixture holder had rust. -The outside on the door on the side of resident room #14 had scraped wood with a wooden patch. -The same door had wood broken from the door above and below the patch by the door knob. An attempted interview with a resident, who lived in resident room #13, on 8/25/17 at 2:15pm revealed the resident did not want to be interviewed. Observation of resident room #8 on 8/23/17 at 1:26pm revealed:	D 079		

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-The bottom of the entrance door had scraped wood across two areas of the door.
-The bottom of the outside of the entrance door below the door handle to the shared bathroom had a long dark brown stain and an area of the door that was light brown.
-The bottom of the same door had dark gray and dirty stains across the bottom of the door.
-The two wooden closet doors did not close together evenly.

An attempted interview with a resident, who lived in resident room #8, on 8/24/17 at 10:35am revealed the resident did not want to be interviewed.

Observation of the entrance door to resident room #12 on 8/23/17 at 1:29pm revealed the bottom of the door had dark brown stains and scraped wood across the door.

Observation of resident room #7 on 8/23/17 at 1:29pm revealed:
-The bottom of the entrance door had dark gray stains and scraped wood across the door and several spotted areas of white paint from the top of the door to the middle of the door.
-The two wooden closet doors did not close together evenly.
-The vent cover on the ceiling was loosed.

Interview with a resident who lived in Room #7 on 8/23/17 at 1:29pm revealed:
-The entrance door and the closet door had the stains and scraped wood every since the resident had been living at the facility.
-The resident had been living at the facility for two weeks.

Based on record review and interviews, the above

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resident had been living at the facility for over one year.

Observation of the entrance door to resident room #11 on 8/23/17 at 1:53pm revealed:
-The bottom of the entrance door had dark brown stains and scraped wood across the door and several areas of scraped wood in the middle of the door.
-The bottom of the entrance door to the bathroom had dark gray stains and chipped wood at the bottom corner of the door.

Observation of the shared resident bathroom between Room #11 and Room #12 on 8/23/17 at 1:55pm revealed:
-The bottom the bathroom door on the side leading to resident room #12 had scraped wood, dark brown stains and speckles of white paint.
-The middle of the right side of the door had a streak of white paint.

Observation of the entrance door on resident room #14 on 8/23/17 at 1:58pm revealed the outside of the wooden door had scrapes of wood from the top to the bottom of the door.

Observation on A Hall on the left side of resident room #14 on 8/30/17 at 1:58pm revealed:
-A loosed white cord was hanging from the ceiling to a uncovered thermostat on the wall .
-The width of the loosed cord was 1/2 foot.

Observation on A Hall on 8/23/17 at 1:58pm revealed:
-A loosed white cord with two loosed areas was hanging from the ceiling between resident room #12 and the double white doors.
-The width of the first area was 1/2 feet and the width of the second area was 1 1/2 feet hanging

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D 079	Continued From page 41 from the ceiling. Observation of the resident phone area on 8/23/17 at 4:03pm revealed: -There was a loosed long phone cord that extended from the phone and phone jack on the wall to the other side of the wall. -There was another loosed phone cord on the wall that extended a phone jack to the top of the wall. -The phone jack was exposing the wires and had no cover. Interview with a housekeeper on 8/28/17 at 11:40am revealed: -The alarms were cleaned a couple of weeks ago by another housekeeper. -She did not know how often the alarms had been cleaned. -The closet door had not closed evenly for the last 7months. -Residents had not complained about the closet doors. -The telephone cords on A Hall and in the resident phone room had been hanging since she had been working at the facility. -She did not know what was being done to repair the hanging phone cords. Observation of the living room on the C Hall on 8/23/17 at 12:05pm revealed there was a pair of scissor on the floor next to the burgundy recliner. Observation of residents' room #4 on the C Hall on 8/23/17 at 12:50pm revealed a large brown roach was crawling on the floor between the resident's chair and bed. Interview with a resident in Room #4 on C Hall on	D 079		

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8/23/17 at 12:53pm revealed:
-She saw roaches in her room every day.
-The facility was sprayed about once a month by an exterminator.
-The roaches still came out even after the facility was sprayed.

Observation of a half bathroom for residents' room #7 on the C Hall on 8/23/17 at 1:10pm revealed the bucket and frame of a bedside commode with several rust stains.

Interview with a resident in residents' room #7 on the C Hall on 8/23/17 at 1:10pm revealed:
-The rusty bedside commode had been there for several months.
-She was the only one who was used this bedside commode.
-The bedside commode was used when staff gave it to her several months ago.
-Staff did not clean the bedside commode.
-She did not like living in the facility because it was not clean and there was a problem with roaches and flies in the facility.
-She saw roaches on a daily basis in her room and in the C Hall dining room.
-She did not know how often an exterminator sprayed the facility.
-She had not voiced any complaints to the staff about the facility cleanliness or the problems with the roaches and flies.

Observation of residents' room #2 on the C Hall on 8/23/17 at 1:30pm revealed there were four flies flying all around the room.

Interview with a resident in residents' room #2 on the C Hall on 8/23/17 at 1:30pm revealed:
-She complained about the flies in her room to the housekeeping staff and that she saw roaches

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in her room daily.
-The housekeeper sprayed for the flies at least once a day in the facility.
-The facility was sprayed for flies about once every 6 months.

Interview with a housekeeper on 8/23/17 at 1:55pm revealed:
-She sprayed for flies in all of the residents' rooms at their requests.
-There was a problem with flies in the facility because residents were going in and out of the doors.
-She did not know about any problems with roaches in the facility.
-An exterminator had last sprayed the facility about 2 months ago.

Observation of residents' room #5 on 8/24/17 at 1:25pm revealed several roaches were crawling inside of the second closet and inside the top drawer of the chest of drawers next to the closet.

Observation of residents' room #1 on the C Hall on 8/25/17 revealed that there 2 dead roaches on the floor next to the bed by the window and one large roach was crawling across the floor.

Interview with the housekeeping supervisor on 8/24/17 at 10:54am revealed:
-He reported if anything needed to be fixed to the Administrator or to the maintenance staff.
-The facility was sprayed for roaches about once a month by an exterminator.
-"It was expected that to see a roach or two in a facility this size".
-When asked when the last time the alarms had been inspected, he did not reply.
-Currently, maintenance was painting, sanding and staining the closet and room doors in the

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D 079	Continued From page 44 facility. Interview with the maintenance staff for the facility on 8/24/17 at 11:10am revealed: -He worked part-time at the facility 3 days a week. -There was only so much repairs he could do in that time. -The Administrator gave him a list of needed repairs and he prioritized what needed to be done first. -He was working on painting the scarred doors and repairing the holes in doors. -He would have to check on the rusted water fixtures to see what could be done. Confidential interviews with three residents revealed: -Both residents complained of seeing roaches in their rooms every day. -One resident voiced that a fear of roaches getting into their hair and laying eggs. -Both residents had voiced complaints to the Administrator at various times about the roaches in the facility. -A third resident said, "The roaches and flies were about to take over this place". -The resident had seen roaches in the closet and dresser. -The housekeeper sometimes sprayed for flies in the room. -The exterminator sprayed the residents' rooms for roaches. -The resident could not specify how often the exterminator sprayed the residents' rooms or the last time the facility was sprayed for roaches. Interview with the local pest control company on 8/28/17 at 12:55 p.m. revealed: -He received a call from a representative at the	D 079		

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facility on 8/24/17 to evaluate needed pest services.
-He started servicing the facility on 8/28/17 and sprayed the facility for roaches.
-He had put roach baits in some of the closets, because there was evidence of roaches in the closets at the facility.
-He planned to come back to the facility next week to check on the roach baits.
-He would continue servicing the facility monthly for roaches after his follow-up visit next week.
-There was evidence of roaches in the residents' rooms on the C Hall and the Special Care Unit.
-He did not know how long it would take to get rid of the roaches.
-He assumed after 3 to 4 treatments.
-He did not see anything that could have caused the roaches.
-He did not know the last time the prior pest control company serviced the facility for roaches.

Review of facility pest control records revealed:
-Pest control services were provided on 12/28/16, 1/18/17, 2/16/17, 3/29/17, 4/19/17, and 5/19/17.
-There was no records of pest control services after 5/19/17.

Interview with the Administrator on 8/29/17 at 1:30pm revealed:
-The facility had a maintenance person who worked the facility 3 days.
-He had a list of repairs but he could only be expected to do so much.
-It sometimes seemed like things were being broken as soon as they were fixed.
-Staff did let her know if any repairs were needed at the facility.
-It was her responsibility to call maintenance with any needed repairs for the facility.
-The maintenance person was working on

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D 079	Continued From page 46 painting the scarred doors on the hallway. -A new pest control company had sprayed the facility on 8/28/17. -The facility had changed pest control company after May 2017.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 12 of 12 water fixtures in the residents' bathrooms and the common hall shower room on the A Hall, C Hall, and Special Care Unit (SCU). The findings are: Observations of water temperatures on the Special Care Unit (SCU) on 8/25/17 from 10:00am-11:00am revealed: -The temperature at the sink in the shared	D 113		

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D 113	Continued From page 47 bathroom of residents' rooms #1 and #2 was 82 degrees F. -The temperature at the sink in the shared bathroom of residents' rooms #3 and #4 was 81 degrees F. -The temperature at the sink in the shared bathroom of residents' rooms #5 and #6 was 81 degrees F. -The temperature at the sink in the common hall shower room #1 was 80 degrees F. -The temperature at the sink in the common hall shower room #2 was 81 degrees F. Confidential interview with one resident revealed the water temperature was always cold in the facility. Observations of water temperatures on the A Hall on 8/25/17 from 1:20 pm to 1:30 pm revealed: - The shared half bath between Resident Rooms #16 and #17 sink faucet had a temperature of 120. -The community bath at the end of the A hall had a hot water temperature of 121 at the faucet, 120 degrees in the shower, and 121 degrees in the tub. Observation of the water temperatures on the A Hall on 8/29/17 at 8:30 am revealed: - The shared half bath between Resident Rooms #16 and #17 sink faucet still had a temperature of 120. -The community bath at the end of the A hall still had a hot water temperature of 121 at the faucet, 120 degrees in the shower, and 121 degrees in the tub. Interview with a resident on 8/28/17 at 5:40 pm revealed:	D 113		

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-He took showers in the last common shower room on the A hall.
-The water could get pretty hot.
-He liked his shower water hot but would add cold to make it comfortable.

Interview with a second resident on 8/28/17 at 6:05 pm revealed:
-He showered in the last common shower room on the A hall.
-The water felt okay to him.
-He was able to add in cold water when needed and had not had any problems.

An attempted interview with a third resident was not successful due to the resident's mental status.

Observations of water temperatures on the C Hall on 8/25/17 from 12:55pm-1:30pm revealed:
-The temperature at the sink in the common hall shower room across from residents' room #7 and residents' room #8 was 84 degrees F.
-The temperature at the sink in the bathroom in residents' room #14 was 96 degrees F.
-The temperature at the sink in the bathroom of residents' room #15 was 98 degrees F.
-The temperature at the sink in the shared bathroom between residents' room #1 and residents' room #2 was 88 degrees F.
-The temperature at the sink in the common hall shower room across from residents' room #6 was 94 degrees F.

Confidential interview with a resident revealed:
-The water had to run from the faucet or shower for at least 3-5 minutes before it got hot.
-"The water did not get hot but warm since the first week in July (2017)".
-The resident had not complained about the

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D 113	Continued From page 49 temperature of the water to any staff or the Administrator. Confidential interview with a second resident revealed: -"The water had not been hot for at least a month". -The water did not get hot even after it ran for 10 or 15 minutes. -The resident heard a staff member complain about the water temperature when giving another resident a bath in the shower room. -The resident was not sure if the cool water temperatures had been reported to the Administrator. Confidential interviews with three more residents revealed the water did not get hot and it only felt warm when they used the water to bathe. Interview with the Administrator 8/25/17 at 4:58pm revealed: -She was not aware of any further problems with the water temperatures in the facility. -She thought "the water temperatures were fine because she had not gotten any complaints from the residents or staff". -She did routinely check the water temperatures about once a week on each of the halls. -She would post signs in the residents' rooms and the common hall bathroom on the A Hall to advise the residents and staff to be careful when using the water on the A Hall because it was too hot. -She would adjust call a repairman on 8/25/17 to adjust thermostats on the hot water heaters and recheck the water temperatures in the facility. Interview with the Administrator 8/28/17 at 9:45am revealed: -She had called a repairman to check the water	D 113		

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heaters over the weekend because one of the water heaters had gone off line.
-She had not rechecked the water temperatures yet but she would check the water temperatures later in the morning.
-She had not posted any hot water signs on the A Hall in the bathrooms where water temperatures were elevated on 8/25/17.
-This was an old building and sometimes there were going to be water fluctuations.

Confidential interview with a staff member on revealed:
-She did not know about any complaints about the water temperature on the C Hall.
-She was not aware of any recent complaints from residents that the water was cold or the water did not get hot enough until 8/28/17.

Observations of water temperatures on the C Hall on 8/28/17 from 5:25pm-5:40pm revealed:
-The temperature at the sink in the shared bathroom between residents's room #7 and residents' room #8 was 100 degrees F.
-The temperature at the sink in the common hall shower room across from residents' room #7 and residents' room #8 was 96 degrees F.
-The temperature at the sink in the shared bathroom between residents' room #13 and residents' room #14 was 96 degrees F.
-The temperature at the sink in the common hall shower room across from residents' room #6 was 100 degrees F.
-The temperature at the sink in the shared bathroom between residents' room #5 and residents' room #6 was 104 degrees F.

Interview with the Administrator on 8/28/17 at 5:45pm revealed:
-She had not posted any hot water signs on the A

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Hall because when she checked the water temperatures earlier they were fine.
-She would call her local maintenance person on 8/28/17 to come out and check the water heaters again.
-She was not sure if the maintenance person checked any of the water temperatures when they did the service call during the past weekend.
-She would post the hot water signs on the A Hall to warn the residents.

Observation revealed that all of the surveyors' thermometers were calibrated with an ice water bath at 32 degrees Fahrenheit on 8/29/17 at 8:22am.

Observation of water temperatures on the A hall on 8/29/17 at 9:15 a.m. revealed:
-The shared bathroom between residents' rooms #16 and #17 continued to have a temperature of 120.
-The community bath at the end of the A hall still had a hot water temperature of 121 at the faucet, 120 degrees in the shower, and 121 degrees in the tub.
-No hot water signs were posted in the shared bathroom for residents' room 16 and 17 or the common hall shower room on A Hall.

Interview with the Resident Care Coordinator on 8/29/17 at 8:23am revealed:
-She did not know anything about any problems with water temperatures in the facility.
-No residents had complained to her about any problems with the temperature of the water.

Observation of the A Hall on 8/29/17 at 9:15am revealed the hot water signs had not been posted.

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D 113	Continued From page 52 Interview with the housekeeping supervisor on 8/29/17 at 9:30am revealed the hot water temperatures had been fixed because the local maintenance person fixed the hot water on 8/29/17. Interview with the lcoal maintenance person for the facility on 8/29/17 at 12:20pm revealed: -The Administrator had called their business over the previous weekend because a water heater had stopped working. -He had come out to the facility and made sure the hot water heater was working. -He found that the hot water for the Special Care Unit was not working so he fixed it. -The Administrator did not ask himto check the hot water temperatures or complained about having any problems with the hot water temperatures during the visit over the weekend. -The Administrator did call this morning to ask him to check the water temperatures. -He planned to come to the facility later on the afternoon of 8/29/17. Interview with the housekeeping supervisor on 8/29/17 at 1:50pm revealed the hot water thermostats had been set at 115 degree F by the repairmen when they came out on 8/29/17 at 9:30am. Attempted phone interview with the Executive Director on 8/30/17 at 8:15am was unsuccessful. The failure of the facility to ensure hot water temperatures were maintained between 100 - 116 degrees F resulted in 5 of 5 water fixtures used by residents on C Hall being below 100 degrees F; 2 of 2 water fixtures used by residents on the A Hall being above 116 degrees F; 5 of 5 water fixtures used by residents in the Special Care	D 113		

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D 113	Continued From page 53 Unit being below 100 degrees F; and the Administrator failing to post caution signs for elevated water temperature for 4 days subjected residents to bathe in cooler water temperatures on the C Hall and Special Care Unit and pick residents on the A Hall at risk of being burned by elevated water temperatues. This failure was detrimental to the welfare and safety of the residents and constituted a Type B Violation. Review of the facility's Plan of Protection dated for 8/25/17 revealed: -The Administrator checked the water temperatures for the rooms on the A Hall, C Hall, and Special Care Unit on 8/25/17. -The Administrator called the local maintenance person to come and adjust the thermostats on the hot water heaters in the facility on 8/25/17. -The Administer will ensure if the hot water temperature is not at the required range for the safety of the residents then, the Administrator will contact the local maintenance person immediately. -The Administrator and the facility maintenance person will continue to check the water temperatures in the facility daily for 1 week and then weekly to ensure that water temperatures are in compliance. -Staff will monitor water temperatures in the facility and report to the facility maintenance person immediately if any issues with the water temperatures. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 15, 2017.	D 113		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	Continued From page 54 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled (Staff F) had no substantiated findings listed on the Health Care Personal Registry prior to the date of hire and failed to perform a Health Care Personal Registry check for 1 of 2 sampled staff (Staff A) prior to the date of hire. The findings are: 1. Review of Staff F's perpetual staff log revealed: -Staff F was hired at the facility on 11/6/08 as the Resident Care Coordinator for the Special Care Unit. -It was documented that a Health Care Personnel Registry (HCPR) check was completed on 11/5/08 for Staff F. -The results from the HCPR check for Staff F completed on 11/05/08 were not documented. Review of Staff F's personnel record revealed Staff F had substantiated findings of neglect from a HCPR check dated 8/23/17 and would have been present on the HCPR on 11/6/08. Interview with the Administrator on 8/29/17 at 5:30pm revealed:	D 137		

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D 137	Continued From page 55 -She had been the Administrator at the facility since 2010. -She became aware of Staff F's substantiated findings in June 2017 during an investigation of Staff F by the HCPR. -She would not have hired Staff F if she had known Staff F had prior substantiated findings on the HCPR. -Staff F was hired by a previous Administrator in 2008. -She thought Staff F was cleared of the prior substantiated findings on the HCPR from 2008 and Staff F had a letter saying that she was cleared of the prior substantiated findings on the HCPR. -She would have to contact Staff F to get a copy of the letter clearing Staff F of the prior substantiated findings on the HCPR. Second interview with the Administrator on 8/29/17 at 6:30pm revealed: -The Administrator had spoken with Staff F on 8/29/17 and Staff F had a copy of a letter that cleared Staff F of the prior substantiated findings on the HCPR. -Staff F would bring the Administrator a copy of the letter on 8/30/17. Telephone interview with Staff F on 8/29/17 at 6:43pm revealed: -She did not have a letter that cleared her of the prior substantiated findings on the HCPR found in 2008. -She was trying to start the process to get the finding cleared off her HPCR record. Interview with the Administrator on 8/29/17 at 6:55pm revealed: -Staff F would be put on suspension until the findings for Staff F were cleared from her HCPR	D 137		

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D 137	Continued From page 56	D 137		

record.
-She was not aware that Staff F could not continue working at the facility since she was technically hired by the previous Administrator with the HCPR findings.

2. Review of Staff A's personnel record revealed:
-She was hired to work at the facility as a medication aide (MA) on 7/25/17.
-There was no documentation of a NC Health Care Personnel Registry (HCPR) check on file in Staff A's record.

Telephone interview with Staff A on 8/29/17 at 6:21pm revealed:
-She was hired to work at the facility as a MA on 7/28/17.
-She gave the business office manager consent to check her HCPR before hired.
-She did not remember the date she gave the business office manager consent to check her HCPR.

Interview with the Administrator on 8/29/17 at 5:39pm revealed:
-Staff A's HCPR check had not been completed.
-She did the HCPR check on Staff A on 8/29/17 after Staff A's employee file was requested as part of the survey review.
-"It was an oversight."
-HCPR should have been checked for Staff A before she was hired to work at the facility.
-The business officer manager checked the HCPR prior to hiring new staff.
-Staff, who have substantiated findings on the HCPR, were not hired to work at the facility.
-The Administrator randomly pulled 5-6 staff personnel records every 6 months to make sure the documentation of HCPR checks were in the files.

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D 137	Continued From page 57 -She eventually looked at all staff personnel files (44) within a year to make sure there was documentation of a HCPR check in each file. A second review of Staff A's personnel record revealed: -A HCPR check was completed on 8/29/17. -Staff A was not listed on the HCPR and had no substantiated findings. The facility failed to ensure Staff F did not have any substantiated findings on the Health Care Personnel Registry(HCPR) and to complete a HCPR check on Staff A prior to date of hire. The facility's noncompliance placed all residents at substantial risk for serious neglect and abuse and constitutes a Type A2 Violation. Review of the facility's plan of protection dated for 8/29/17 revealed: -The Administrator performed a North Carolina Health Care Personnel Registry check for Staff F on 8/29/17. -The Administrator suspended Staff F immediately from work pending further reference from the HCPR and the results of the pending investigation. -The Business Office Manager and the Administrator will continue to follow protocol for any employees is reviewing the NC HCPR for each employee to make sure they are in compliance and free from any substantiated findings before hiring. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2017.	D 137		

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D 273	Continued From page 58	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to coordinate mental health services for 1 of 7 sampled residents (#5) with a documented history of physical aggression, being verbally abusive and displayed episodes of erratic behaviors. The findings are: Review of Resident #5's current FL-2 dated 2/7/17 revealed: -Diagnoses included Alzheimer's dementia, schizophrenia, intellectual disability, and seizure disorder. -Resident #5 was intermittently disoriented. -The resident was semi-ambulatory with a wheelchair. -Medications included Zoloft 100mg daily (Zoloft is a medication used to treat depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, and post-traumatic stress disorder). Review of Resident #5's Resident Register revealed an admission date of 1/18/17. Review of a physician's order for Resident #5	D 273		

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dated 4/21/17 revealed there was an order for Ativan 1mg every 6 hours as needed for anxiety and agitation (Ativan is a medication used to treat anxiety disorders).

Review of Resident #5's care plan dated 1/30/17 revealed:
-Resident #5 was verbally abusive, physically abusive, and displayed disruptive and socially in appropriate behaviors.
-Resident #5 was sometimes disoriented and forgetful.
-Resident #5 required limited assistance with eating, toileting, ambulating, and transferring.
- Resident #5 required extensive assistance with bathing, dressing, and grooming.
-Resident #5 was not receiving Mental Health Services as of 1/23/17.
-Resident #5 had an assessed need for mental health services.
-Resident #5 was resistant to care and needed to be redirected.
-Resident #5 was injurious to others and property.
-The care plan was signed by the primary care provider.

Review of a progress note for Resident #5 dated 1/18/17 revealed Resident #5 was admitted to the facility's Special Care Unit (SCU) on 1/18/17.

Review of Resident #5's Special Care Unit quarterly profile dated 7/19/2017 revealed:
-Resident #5 was alert and oriented to person only.
-Resident #5 was depressed, anxious, noisy, overactive, belligerent, and sometimes pleasant.
-Resident #5 did not participate in activities.

Review of physician visit notes for Resident #5 revealed mental health services had not been

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provided since Resident #5 was admitted on 1/18/17.

Review of a progress note for Resident #5 dated 6/24/17 for the 7-3 shift revealed:
-Resident #5 was spitting on other residents.
-One of the other residents hit Resident #5 with a walker on his left leg and left arm.
-A medication aide had to separate Resident #5 and the other resident.

Review of a progress note for Resident #5 dated 7/12/17 for the 3-11 shift revealed:
-Resident #5 was agitated for unknown reasons and called the staff and residents foul names (foul names were not specified).
-Resident #5 stuck out his foot and tried to trip another resident.
-The other resident pushed Resident #5 and the medication aide took control of the situation to calm both residents.

Review of a progress note for Resident #5 dated 7/12/17 revealed:
-The shift time was not documented.
-Resident #5 constantly threw himself onto the floor from his wheelchair intentionally.
-Resident #5 refused to allow staff to change his incontinence brief.
-Resident #5's family member said, "He was sorry for the way Resident #5 was acting but it was nothing that he could do about it".
-Resident #5's family member suggested staff ask the physician to increase Resident #5's psychiatric medications.
-Staff did call the on-call physician but the physician did not answer.

Review of a progress note for Resident #5 dated 7/23/17 revealed:

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D 273	Continued From page 61 -The shift time was not documented. -Resident #5 became upset with another resident because the other resident turned off the light in the dayroom. -Resident #5 began calling other resident "out of his name" and started spitting on the other resident. -A physical altercation started between Resident #5 and the other resident. -The primary care provider and Resident #5's family member were both notified. Review of a physician office note for Resident #5 dated 7/24/17 revealed: -Resident #5 had a history of aggressive behavior, spitting on people, and name calling. -These behaviors resulted in an altercation with another resident. -Attempts to talk to Resident #5 about his behavior were not beneficial. -The physician's office had asked the assisted living staff to make sure Resident #5 was aware of his behaviors and try to stay out of his way. Review of a progress note for Resident #5 dated 7/26/17 revealed: -The shift time was not documented. -Resident #5 was yelling and cursing all morning. -Resident #5 attempted to take a chair away from another resident. -Resident #5 was spitting on staff and tried to throw a cane. -Resident #5 sat down on the floor and began screaming. -Resident #5 was assisted up from the floor and then began cursing and using racial slurs. -The primary care provider and Resident #5's family member were both notified. Review of a second progress note for Resident	D 273		

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#5 dated 7/26/17 revealed:
-The shift time was not documented.
-Resident #5 sat down on the floor and started yelling and cursing.
-Staff assisted Resident #5 off the floor.
-Resident #5 continued yelling and cursing at the staff.
-Resident #5 spat repeatedly on the floor and threw a chair at the Special Care Coordinator.
-There was no documentation that the primary care provider was notified.

Review of a progress note for Resident #5 dated 7/28/17 during the 11pm-7am shift revealed:
-Around 3:24am on 7/29/17, staff told the supervisor that Resident #5 was yelling.
-The supervisor found Resident #5 on the floor and staff assisted Resident #5 back to bed.
-Resident #5 put himself on the floor again and staff called 911.
-The emergency medical technicians (EMTs) assisted staff to get Resident #5 back to bed.
-Resident #5 slid himself out of the bed again after the EMTs left.
-Staff called Resident #5's family member and the family member told the staff not to send Resident #5 out for medical evaluation unless he was hurt.

Review of a progress note for Resident #5 dated 7/29/17 during the 3pm-11pm shift revealed:
-Resident #5 was very irate.
-The staff had to remove Resident #5 from the floor several times.
-Resident #5 was talking loudly, screaming and using "vulgar" language.

Observation of Resident #5 in the Special Care Unit on 8/23/17 at 12:15pm revealed:
-Resident #5 did not socialize with other residents who shared a table with him during lunch.

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D 273	Continued From page 63 -Other residents appeared nervous and watching Resident #5 closely. Observation of Resident #5 in the Special Care Unit on 8/24/17 at 3:00pm revealed: -Resident #5 did not participate in social activities with other residents. -Staff and other residents did not try to socialize with Resident #5 on 8/24/17. Observation of Resident #5 in the Special Care Unit on 8/25/17 at 8:00am revealed Resident #5 was watching television alone in his room quietly. Interview with Special Care Unit Coordinator on 8/25/17 at 10:00am revealed: -Resident #5 was not receiving mental health services. -A mental health referral was made for Resident #5 when he was admitted to the SCU (date was not specified). -Resident #5 had not gotten any mental health services because there was a problem with his Mediciad coverage coming from another county. -The business office manager was working on getting Resident #5's Medicaid changed to this county so he can get his mental health services. -Resident #5's primary care physician (PCP) managed the mental health care for Resident #5. -Resident #5 had several episodes when he'd spit, hit, used racial slurs, curse, and yelled at other residents and staff. -She could not specify how many times this had occurred since Resident #5 had been admitted in the SCU. -Resident #5's PCP had not given the staff any interventions to manage Resident #5's behaviors when he was yelling, cursing, or hitting the residents and/staff. -Staff just tried to keep other residents away from	D 273		

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D 273	Continued From page 64 Resident #5 when he was acting out. Interview with the business office manager on 8/25/17 at 1:00pm revealed: -Resident #5 needed to have his Medicaid switched to this county to receive mental health services. -Resident #5's PCP would make the mental health referral and the facility would coordinate the appointment for mental health service. Interview with a county Department of Social Services worker on 8/25/2017 at 12:00pm revealed: -Resident #5's Medicaid case reported Resident #5 was in another county. -It did not matter where in the state a resident was from for Medicaid to pay for mental health services. Interview with the Special Care Coordinator on 8/25/17 at 2:05pm revealed: -She talked with the business office manager in January 2017 or February 2017 about getting Resident #5's Medicaid changed to this county. -She did not know if Resident #5's Medicaid had been changed yet. -She did not follow-up with the business office manager about Resident #5's Medicaid coverage. Interview with the Administrator on 8/25/17 at 4:30pm revealed: -She was not aware that Resident #5 had not been receiving mental health services. -No one had told her that Resident #5's Medicaid needed to be changed. -Resident #5's primary care provider (PCP) was in charge of managing Resident #5's care. -She would have to speak with the Special Care Coordinator to see what could be done.	D 273		

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D 273	Continued From page 65 -The Special Care Coordinator was in charge of following up if residents in the SCU needed referrals. -Resident #5 did have a problem with hitting and spitting on other residents and staff in the SCU. -Staff tried to keep other residents away from Resident #5 when he acted out. Interview with the PCP for Resident #5 on 8/25/17 at 5:45pm revealed: -He was the primary care provider for Resident #5 and he was providing mental health services for Resident #5. -He did not make a mental health referral for Resident #5 because he as qualified to provide mental health services. -His practice was family medicine but he was qualified to provide mental health services. -Resident #5 had a history of hitting, spitting, and calling other names. -Resident #5 was "prejudice and did not like African American people taking care of him". -His goal to manage Resident #5's behaviors was to find "a happy balance that minimized the use of medications and use behavior modification". -He had advised the SCU staff to use the behavior modifications to deal with Resident #5's behaviors, but he could not specify the behavior modifications that he had given to the staff. -He had adjusted Resident #5's psychiatric medications and there was nothing else that he could do. Confidential interview with a staff member revealed: -It was hard to get Resident #5 to calm down when he got agitated. -Staff had to separate him from the other residents in the SCU by taking him to his room.	D 273		

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D 273	Continued From page 66 Interview with Resident #5 on 8/29/17 at 4:35pm revealed: -He liked to keep to himself. -He hit other residents if they got in his way. -He could not specify who the residents were he had hit. -He denied spitting, cursing, using racial slurs, or hitting staff. -He wanted to be left alone to watch television. Interview with the SCC on 8/29/17 at 9:30am revealed: -Resident #5's Medicaid coverage had been changed to reflect his residence. -She made an appointment for Resident #5 for mental health services for 9/18/17 at 2:00pm. Interview with a family member for Resident #5 on 8/29/17 at 9:50am revealed: -The family member was aware that Resident #5 had several altercations with residents and staff since he had been at the facility. -Resident #5 had used profanity, hit and spit on both residents and staff at the facility. -Resident #5 had been discharged from several other facilities because of his behaviors. -The family member had talked with the SCC and PCP in January 2017 about having Resident #5 re-evaluated because of Resident #5's mental health problems. -The PCP told him that there was a problem with getting Resident #5's insurance to cover mental health services for Resident #5. -The family member did not talk with the business office manager or the Administrator about getting Resident #5's mental health re-evaluated. The facility failed to provide the services necessary to maintain the mental health wellbeing for 1 of 7 sampled residents (#5), by not following	D 273		

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D 273	Continued From page 67 through with mental health services for Resident #5, who had schizophrenia and an intellectual disability. The facility's failure resulted in the resident displaying episodes of erratic behaviors and other residents and staff in a Special Care Unit being subjected to Resident #5's physical and verbally aggression/assault. The facility's failure to coordinate mental health serivces for Resident #5 is serious neglect and constitutes a Type A2 Violation. Review of the Facility's plan of protection dated for 8/25/17 revealed: -The Administrator will immediately have the Special Care Coordinator and the Resident Care Coordinator to contact the mental health providers for the resident to receive mental health services. -The Special Care Coordinator and the Resident Care Coordinator will consult with each resident to ensure that proper services are provided accordingly. -The Special Care Coordinator and the Resident Care Coordinator will continue to follow up on the needs of the residents where health care services are needed to ensure all residents will see the proper provider as needed for care. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2017.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas	D 282		

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D 282	Continued From page 68 shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to keep the food storage areas, 2 reach-in freezers, ice machine, 2 reach-in coolers, hand sink, and the kitchen walls clean and free from contamination. The findings are: Observation of reach-in freezer A in the kitchen on 8/23/17 at 2:31 pm revealed: -There was a brown build up around the gaskets of the cooler. -There were areas of black stains on the gaskets. -There was a dried, yellow food stain on the side of the cooler door. Observation of reach-in freezer B in the kitchen on 8/23/17 at 2:31 pm revealed: -There was a brown build up around the gaskets of the cooler. -There was a dried, white food stain on the top and side of the cooler door. Observation of the ice machine in the kitchen on 8/23/17 at 2:33 pm revealed: -There were grease stains on the side and front of the machine. -There was dust accumulated on the gaskets of the cooler. -The vent cover had dust. Observation of a reach-in cooler on 8/23/17 at 2:36 pm revealed: -There were several brown food stains on the bottom shelf. -There were dried, white food stains on the grates	D 282		

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D 282	Continued From page 69 at the bottom of the cooler. Observation of reach-in cooler in the kitchen on 8/28/17 at 5:07 pm revealed: -The yellow food stains had been cleaned from the sides of the cooler door. -The gaskets of the cooler still had black stains. Observation of reach in freezer B on 8/28/17 at 5:07 pm revealed there was a brown substance at the bottom of the cooler by the door. Observation of the ice machine on 8/28/17 at 5:08 pm revealed the machine had been cleaned but there were still some grease streaks on the side. Observation in the kitchen on 8/23/17 at 2:39 p.m. revealed: -The inside of the hand sink had yellow and gray stains. -The top of the sink around the caulking had built-up black, gray and yellow stains. -The area of the wall above and beside the hand sink had yellow and specks of multiple black stains. -The bottom of the back exit door had rust across the bottom. -The area of the floor in front of the exit door had white dried stains built-up in the grout. Observation of the dry goods storage area on 8/23/17 at 11:44 a.m. revealed: -The light switch was stained brown in multiple areas. -The area of the wall around the light was stained dark brown. -The area of the wall behind the sugar and pepper packet bins was stained yellow, gray and orange.	D 282		

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D 282	Continued From page 70 Interview with the Cook on 8/29/17 at 6:25 p.m. revealed: -There was a weekly schedule for cleaning the kitchen. -There were "Dietary Cleaning Schedule" sheets in a book in the kitchen. -Staff initialed each area of the sheet after completing the task. Review of the "Dietary Cleaning Schedule" for the week of 8/20/17 through 8/26/17 revealed: -The outside of the reach-in coolers were documented as cleaned at the end of each shift. -The ice machine doors, tops, and sides documented as had been cleaned daily. -The insides of the reach in freezers had been documented as cleaned weekly. -The bottom shelf and legs of the sinks were to be cleaned weekly -The baseboards were documented as wiped down weekly. -The floors were cleaned with a chemical after each meal. -The storage area was cleaned inside weekly and as needed. Review of the "Dietary Cleaning Schedule" for 8/27/17 revealed that none of the cleaning tasks had been completed. Review of the "Kitchen Responsibilities" form (not dated) included: -On Mondays, clean the refrigerators and freezers. -"Wash inside and out." -"Everything must be taken out." Telephone interview with the Administrator on 8/30/17 at 9:32 a.m. revealed: -Dietary staff knew the kitchen should be cleaned.	D 282		

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D 282	Continued From page 71 -Dietary have a cleaning schedule. -The reach-in cooler and reach-in freezer was supposed to be wiped daily with hot soapy water. -The ice machine was supposed to be wiped daily and as needed with hot soapy water. -The vent covers on the reach-in cooler were supposed to be cleaned weekly with hot soapy water. -The floor in the kitchen was supposed to be mopped daily. -The tile in the A Hall dining room was currently being replaced. -She checked the cleanliness of the kitchen and the dining rooms daily. -If something needed to be cleaned in the kitchen, she told dietary staff.	D 282		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the food cart used to transport food to the residents was cleaned and the food served to the residents during meals was protected from contamination. The findings are: Observation of the lunch meal in the Special Care Unit (SCU) on 8/23/17 at 11:40am revealed: -Lunch trays were transported to the dining room	D 283		

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of the SCU in an enclosed serving cart with black dirt buildup around all 4 wheels of the cart.
-The prepared lunch was baked pork chops with gravy, brussels sprouts, macaroni and cheese, a roll and vanilla pudding cup for dessert.
- The pudding cups were served to 18 of 18 residents on the same plate as the hot food.

Observation of the food storage cart on 8/23/17 at 2:35pm revealed:
-The outside of the cart had several grease stains.
-The green doors on the outside of the cart had built-up black stains.

Observation of the dinner meal in SCU on 8/24/17 at 5: 30pm revealed:
-The prepared dinner was a deli sandwich (turkey white meat), fruit cup, tossed salad, and potato chips.
-Dinner trays were transported to the dining room in an enclosed serving cart with black dirt buildup along all 4 wheels of the cart.
- The bags of potato chips were served on top of the other food items under the plate covering for 17 of 18 residents served.

Observation of the dinner meal in SCU on 8/24/17 at 5: 30pm revealed:
-Dinner trays were transported to the dining room in an enclosed serving cart with black dirt buildup around all 4 wheels of the cart.
-The prepared lunch was ½ baked potato, mixed vegetables, hamburger steak with gravy and cantaloupe.
-The fruit bowls were plated on the same plates with the hot food items for 18 of 18 residents served.

Observation of the breakfast meal in the SCU on

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D 283	Continued From page 73 8/25/17 at 7:15am revealed the breakfast trays were transported to the dining room in an enclosed serving cart with black dirt buildup around all 4 wheels of the cart. Interview with personal care aide on 8/24/17 at 5:30pm revealed: -All meals were always prepared and transported from the kitchen using the enclosed cart. -The meals had always been served with the chips, bowls and other items on the same plate as the hot food. -This was how the kitchen sent the food from the kitchen inside the cart. Observation of lunch in the C Hall dining room on 8/24/17 at 11:45am revealed that all sixteen residents were served bowls of cantaloupe chunks plated on the plate with their hamburger steak. Observation of dinner in the C Hall dining room on 8/24/17 at 5:30pm revealed: -All sixteen residents received their dinner places with their bags of potatoes lying on top of their deli sandwiches. -Thirteen residents were served bowls of mixed fruit plated on the plate with their deli sandwiches. Observation of breakfast on 8/25/17 for the C Hall at 7:33am revealed: -The dietary staff brought the breakfast trays from the kitchen in a food warmer cabinet. -A metal baking sheet that contained 11 bowls of cereal was on top of the food warmer cabinet. -A gray plastic tray was sitting on top of the 11 bowls of cereal and it contained 4 bowls of cereal. -There was no covering between the 11 bowls of cereal and the gray plastic tray.	D 283		

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D 283	Continued From page 74 Interview with a Dietary Aide on 8/25/17 at 7:35am revealed: -The facility only had one food warmer cabinet to transport food from the kitchen to the C Hall dining room. -This is the way they had to bring the food from the kitchen to the C Hall dining room without having to make 2 trips. Interview with the Cook on 8/24/17 at 5:45pm revealed: -The Administrator told her on 8/24/17 to put a roll on top of the fruit and to not put the dessert in a bowl and the bowl inside of a plate with the resident's food. -She had been putting the rolls on top of the fruit and the bowls on the plate for a while. Interview with the Cook on 8/28/17 at 4:50pm revealed: -The Dietary Aide cleaned the food cart twice weekly. -The facility had the food cart for "20 years." Interview with the Dietary Aide on 8/28/17 at 4:50pm revealed: -She cleaned the food cart every two days. -She cleaned the cart by taking it outside and spraying it with a water hose. Interview with the Administrator on 8/24/17 at 5:38pm reveled: -She was responsible for dietary. -They have always put the bowls on the plate with the food. -The bowls and plates were clean. -She did not know the bowl inside of the plate could contaminate the food.	D 283		

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D 283	Continued From page 75 -Her expectation was for dietary to follow sanitation and safety guidelines when preparing and serving meals. -She thought dietary was following sanitation and safety guidelines. Telephone interview with the Administrator on 8/30/17 at 9:32am revealed: -She was responsible for dietary. -She monitored dietary daily. -The food cart needed to be cleaned daily.	D 283		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate, palatable meals a day at regular hours with at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents were served meals which were adequate and palatable. The findings are: Review of the Wednesday "Weekly Menu Spring/Summer 2017-Week 3" Lunch Menu revealed the residents were to receive glazed pork chop, macaroni and cheese, roasted brussel sprouts, banana split desert and roll. Observation during the lunch meal on 8/23/17 at 12:05 pm revealed the residents were served 1 pork chop, 1/2 cup of macaroni and cheese, 1 roll, 3 brussel sprouts, 2 ounces (oz) of banana	D 297		

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pudding, 12 oz tea and 6 oz water.

Interview with a resident on 8/23/17 at 12:14 pm revealed:
-The lunch was not good.
-The brussel srouts were not cooked completely.
-She choked on the food.
-The dietary staff did not know how to cook.
-The macaroni and cheese tasted good.

Interview with a second resident on 8/23/17 at 12:17 pm revealed:
-The brussel sprouts were too hard.
-The pork chop was also too hard.
-The macaroni and cheese tasted good.

Review of the Thursday "Weekly Menu Spring/Summer 2017-Week 3" Lunch Menu revealed the residents were to receive cube steak with gravy, baby baked potato, succotash, melon cup and roll.

Observation of Resident #8 during lunch on 8/24/17 for the C Hall at 11:55am revealed:
-Resident #8 was served a whole hamburger steak patty with gravy, a baked potato, mixed vegetables, a roll, and a bowl of cantaloupe chunks with milk, fruit drink, and water.
-Resident #8 ate half of her hamburger steak and mixed vegetables without difficulty.
-Resident #8 ate all of her baked potato and cantaloupe chunks without difficulty.
-Resident #8 did not eat any of her roll.
-Resident #8 drank all of her milk and water and drank half of her fruit drink.

Review of the Thursday "Weekly Menu Spring/Summer 2017-Week 3" Dinner Menu revealed the residents were to receive a deli sandwich, chips/pretzels, tossed lettuce salad

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D 297	Continued From page 77 with dressing and ambrosia salad. Observation of Resident #8 during dinner on 8/24/17 for the C Hall at 5:30pm revealed: -Resident #8 was served 1 slice of white bread, chopped deli turkey meat, mixed fruit, tossed salad with dressing, a bag of plan potato chips, milk, tea, and water. -Resident #8 ate all of her bread, chopped turkey, and mixed fruit without difficulty. -Resident #8 drank all of her milk and a half of her tea. -Resident #8 did not drink any of her water. Review of the Friday "Weekly Menu Spring/Summer 2017-Week 3" Breakfast Menu revealed the residents were to receive juice, cereal, eggs, breakfast meat, waffle, syrup and milk. Observation of Resident #8 during breakfast on 8/25/17 at 7:40am revealed: -Resident #8 was served a sausage patty chopped in 4 pieces, a scrambled egg, and a bowl of cornflakes with milk. -Resident #8 was served milk, orange juice, and water as beverages. -Resident #8 ate all of her sausage patty, eggs, and cereal without difficult. -Resident #8 drank all of her milk and orange juice. -Resident #8 did not drink any of her water. Review of Resident Council Meeting notes dated 8/25/17 revealed a resident complained that there needed to be more food on the plates. Interview with a resident on 8/24/17 at 11:50 a.m revealed: -The lunch was not bad.	D 297		

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D 297	Continued From page 78 -The potato was not done and was too hard to eat. -The hamburger steak was cooked properly. Confidential interview with a resident revealed the food was not good at the facility and residents could not get seconds at meal times. Confidential interview with a second resident revealed: -The food at the facility was not appealing. -The food had not taste even when it was seasoned. Confidential interview with a third resident revealed: -The food was not good and it made the resident feel sick to eat it. -Sometimes, the food was not cooked thoroughly and the meat was tough to eat. Interview with a Medication Aide on 8/25/17 at 1:34pm revealed: -When residents complain of the food, she ask them if they want an alternate. -If a resident did not like the meat cooked, they could get a bologna, ham or peanut butter and jelly sandwich. -They have been giving the resident the alternate of a sandwich for over one year. Interview with a Personal Care Aide (PCA) on 8/28/17 at 5:15pm revealed: -When certain staff cook the meals, the residents do not complain about the meals. -When certain staff cook the meals, the residents complain of the food not having enough seasoning and they do not want to eat the meal. Interview with a PCA on 8/29/17 at 3:10pm	D 297		

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revealed:
-The residents complained about the food weekly.
-If the resident did not like what was offered they were offered a sandwich.
-She had not reported to anyone if the residents did not like the meal.

Interview with the Cook on 8/24/17 at 5:46pm revealed:
-She used black pepper, lemon pepper, garlic salt and ground cloves to season the residents food.
-She had not received any complaints from residents or staff about the taste of the food or not getting enough food with the meals.

Interview with the Cook on 8/28/17 at 4:50pm revealed:
-She received dietary training one month ago at the facility.
-The training included how to serve and portion food.

Telephone interview with the Administrator on 8/30/17 at 9:32am revealed:
-She was responsible for dietary.
-She monitored dietary meals daily.
-All of the residents may not like what was served at each meal.
-If the resident did not like what was served, they could receive a sandwich as an alternate.
-She expect the Cooks to prepare the meals "accordingly."
-The lunch meal on 8/23/17 she tasted the brussel sprouts and it was done.
-Some residents came back for more brussel sprouts.
-She could not remember if she tasted the baked potato during the lunch meal on 8/24/17 or not.

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PINEWOOD MANOR	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

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D 298	Continued From page 80	D 298		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure snacks were offered to residents three times daily. The findings are: Observation of the snack time in the Special Care Unit on 8/24/2017 at 2:00pm revealed all residents were served the same snack of peanut butter and jelly sandwich and a drink. Interview with Medication Aide (MA) 8/24/2017 at 3:00pm revealed: -Residents were served snacks only if they are not in the bed. -Residents were not allowed to have snacks while they are in the bed. -Residents are offered snacks 3 times a daily -She did not know why residents were not able to eat snacks if they were in the bed. Interview with a resident on 8/23/17 at 1:04 pm revealed: -He got snacks once daily at 8:00 p.m. -He usually got two to three cookies, vanilla wafers, or graham crackers. -Milk, Kool-Aid, water, or lemonade was given to	D 298		

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D 298	Continued From page 81	D 298		

drink.
-There was sugar in the Kool-Aid and lemonade.

Interview with a second resident on 8/25/17 at 4:07 pm revealed:
-Snacks were typically cookies, graham crackers, or bananas.
-Two to three ounces of juice was given as a beverage.
-Water was always served with bananas.

Interview with a third resident on 8/23/17 at 12:37 pm revealed:
-He only got one graham cracker as a snack.
-He was given two to three ounces of juice in a small styrofoam cup.

Interview with a fourth resident on 8/23/17 at 1:21 pm revealed:
-He got snacks three times daily.
-Snacks were usually cookies.
-He also received a glass of juice at snack time.

Interview with a fifth resident on 8/23/17 at 1:31 pm revealed:
-He got snacks twice daily.
-He usually had cookies or chips.
-He was also given a small cup of juice.

Interview with a sixth resident on 8/23/17 at 1:00 pm revealed:
-He got snacks three times daily.
-He usually was given two to three cookies and a half of a sandwich.
-Water, milk, Kool-Aid, or juice was given at night.

Confidential interview with a resident revealed:
-Staff did not bring snacks down to the residents' rooms at night.
-Residents did not get a snack at night if the

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D 298	Continued From page 82 residents did not go and get the snack from the staff. Interview with a Cook on 8/23/17 at 2:22pm revealed residents were offered snacks at 10:00 a.m., 2:00pm and 8:00pm Interview with the same Cook on 8/23/17 at 2:47pm revealed the diabetics were offered oatmeal cookies, sugar cookies or bananas for snacks. Observation of the pantry on 8/23/17 at 2:47pm revealed packs of sugar cookies, oatmeal cookies, vanilla wafers, graham crackers, canned fruit in light syrup and 100% juice. Observation on 8/24/17 at 10:07am revealed: -A Personal Care Aide (PCA) was going down A Hall (men's) with a snack cart and offering snacks to residents. -The PCA was offering cookies and graham cracker to the residents. Interview with a second MA on 8/25/17 at 1:34pm revealed: -Residents were offered snacks three times daily. -Residents were offered oatmeal cookies, sugar cookies, bananas or yogurt for snacks. -The diabetics were offered sugar cookies, graham crackers, a sandwich, juice or water. -The PCA's passed out snacks to residents in their room. Interview with a PCA on 8/28/17 at 1:18pm revealed: -The PCA's offered and passed out snacks to the residents. -When she went down the hall, she called out "snack cart" to the residents or knocked on the	D 298		

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D 298	Continued From page 83	D 298		

resident's door.
-Residents were offered sugar cookies, oatmeal cookies, graham crackers or kool-aid.

Interview with the Resident Care Coordinator (RCC) on 8/29/17 at 8:21am revealed:
-Snacks were served at 10:00 a.m., 2:00 pm and 8:00 pm to the residents.
-Dietary prepared the snacks and the PCA's passed out the snacks to the residents.
-The diabetics were offered graham crackers, vanilla wafers, juice or water.

Interview with a third MA on 8/29/17 at 10:00am revealed:
-Residents were offered yogurt, bananas, cookies, crackers graham crackers or cake for snacks.
-The residents with diabetes were offered oatmeal cookies, graham crackers yogurt or whole fruit.
-For snacks at 8:00 pm , the diabetics were offered a peanut butter and jelly, bologna or pimento cheese sandwich.
-If a resident with diabetes, blood sugars were high earlier during the day, she does not give that resident juice.
-If a resident with diabetes wanted juice with a snack, she mixed the juice with water.
-She had been mixing the juice with water for residents with diabetes since April 2016.

Interview with a second Cook on 8/29/17 at 5:35pm revealed:
-The residents with diabetes received 1/2 sandwich at the 8:00pm snacks.
-The facility did not have a snack menu.

Interview with the Administrator on 8/29/17 at 5:39 pm revealed the facility did not have a

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D 298	Continued From page 84 snack menu. Telephone interview with the Administrator on 8/29/17 at 9:32am revealed: -Snacks were offered to the residents at 10:00am. 2:00pm and at 8:00pm -Residents were offered cookies, fruit punch, milk lemonade or water. -The diabetics were offered vanilla wafers or graham crackers. -At 8:00pm the residents with diabetes were offered 1/2 bologna, peanut butter and jelly or cheese sandwich and an unsweetened beverage. -Her expectation was for staff to offer snacks to the residents three times daily. -If residents do not receive snacks, they told the Administrator.	D 298		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure milk was served to the residents in the Special Care Unit (SCU) twice daily.	D 299		

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D 299	Continued From page 85 The findings are: Review of the Wednesday "Weekly Menu Spring/Summer 2017-Week 3" Lunch Menu revealed residents were to be served 8 ounces of milk at lunch and dinner. Observation of a sign hung on the wall in the dining room in the Special Care Unit (SCU) stated that milk was served for breakfast and dinner Observation of the refrigerator located in the dining room of the SCU on 8/23/2017 at 11:30am revealed there was 1 gallon of milk inside of the refrigerator. Observation of the lunch meal served in the SCU on 8/23/17 at 11:40am revealed no resident was served or offered milk by the staff during the meal time. Observation of the dinner meal served in the SCU on 8/24/17 at 5: 30pm revealed milk was not served to residents by the staff during the dinner meal. Interview with Personal Care Aide on 08/23/17 at 11:40am revealed: -She knew all residents should be offered and served milk twice a day. -She thought the residents received milk with their evening snack. -Some residents did not want milk during regular meal times. -She served milk during the breakfast when residents asked for it. -She was not aware if any resident(s) were lactose intolerant. Interview with Personal Care Aide on 08/23/17 at	D 299		

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D 299	Continued From page 86 5:30 p.m. revealed: -She served milk at dinner only if the residents requested it. -She offered milk during snack time but no residents requested milk. Confidential interviews with 3 residents revealed that they were not served or offered milk at least twice a day. Telephone interview with the Administrator on 8/30/17 at 9:32am revealed: -Staff poured the resident's milk. -Milk should be served to the residents in the SCU at breakfast and dinner and as requested. -Staff had been serving milk to residents at breakfast and dinner for seven years. -She was not aware staff had not been giving milk to residents during the breakfast and dinner meals.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 2 sampled residents (#12) received nutritional supplements as ordered by the primary care physician (PCP). The findings are:	D 310		

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D 310	Continued From page 87 Review of Resident #12's current FL-2 dated 5/12/17 revealed: -Diagnoses included Alzheimer's Dementia, Gastropathy, Diabetes Mellitus, and Hypertension. -Resident #12 was intermittently disoriented. Interview with Resident #12 on 8/23/17 at 1:55 pm revealed: -He did not get enough to eat. -He did not ask staff for seconds and had never been asked if he wanted more food. -He was diabetic but was on a regular diet. Review of the Snack list in the kitchen on 8/23/17 at 2:29 pm revealed Resident #12 was to receive supplements at 10:00 am, 2:00 pm, and 8:00 pm daily. Review of Resident #12's August 2017 Medication Administration Record (MAR) revealed "facility shakes" three times daily with snacks transcribed on 2/3/2015. -Staff documented that Resident #12 had received facility shakes at 10:00 am and 2:00 pm from August 1 through August 25th. -Staff documented that Resident #12 had received facility shakes at 8:00 pm from August 1 through August 27th. Review of Resident #12's July 2017 Medication Administration Record (MAR) revealed "facility shakes" three times daily with snacks transcribed on 2/3/2015. -Staff documented that Resident #12 had received facility shakes at 10:00 am, 2:00 pm, and 8:00 pm from July 1 through July 31st. Interview with Resident #12 on 8/24/17 at 3:30	D 310		

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D 310	Continued From page 88 pm revealed: -He had not received a shake on 8/24/17. -It had been some time since he was given a shake. -He believed it to be over two months or greater since he last had a shake. -He did not have a preference as to the flavor of the shake. Interview with the Personal Care Aide (PCA) on 8/24/17 at 3:45 pm revealed: -Resident #12 had refused his shake on 8/24/17. -He often refused his shake so that he could have cookies instead. -Resident #12 was not allowed to have cookies and a shake due to being diabetic. -The shake refusal was documented on the "Hourly Rounding Schedule" report sheet. -The PCA also notified the Medication Aide (MA). Review of the "Hourly Rounding Schedule" for 8/24/17 at 3:55 pm revealed a handwritten entry on the back of the form detailing that Resident #12 refused his shake at 10:00 am because he wanted oatmeal cookies. Interview with Resident #12 on 8/25/17 at 10:06 am revealed the resident received his shake last night (8/24/17) at 8:00 pm. Observation of Resident #12 on 8/25/17 at 10:07 am revealed the PCA gave the resident a shake to drink along with a bag of potato chips. Interview with the Medication Aide on 8/25/17 at 10:15 am revealed: -The PCA's had been administering shakes to the residents up until today. -The MA would usually be on the hall at that time and document it was given.	D 310		

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D 310	Continued From page 89	D 310		

-The MA was unaware Resident #12 had not been receiving his shakes.
-The MA would now as of 8/25/17 give the shake to the resident and document it was given on the MAR.

Interview with a second PCA on 8/24/17 at 5:51 pm revealed:
-She did not usually work the men's hall.
-Shakes should be passed out around 7:30 pm.
-She usually gave Resident #12 a sandwich for the 8:00 pm snack.
-Occasionally Resident #12 would also get a shake.
-She documented refusals on the "Hourly Rounding Schedule" if the resident refused and also notified the supervisor.

Interview with Resident #12's family on 8/29 at 9:25 am revealed:
-She had not visited the facility in a few months.
-Resident #12 had several shakes in his room at that time.
-Resident #12 did not like the flavor of the shake he was being offered.
-She was not aware of any weight loss.
-Resident #12 had always been small.
-Resident #12 complained that the food was awful.

Interview with the Resident Care Coordinator (RCC) on 8/29 at 8:25 am revealed:
-PCA's used to give out shakes to the residents until last week on 8/25/17.
- Kitchen staff prepared the snack carts for 10:00 am, 2:00 pm, and 8:00 pm.
-The PCA's were responsible for getting the shakes from the kitchen when needed.
-On 8/25/17, the RCC advised all MA's to pass out shakes and document if the shake was given

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D 310	Continued From page 90 or refused by the resident . Interview with the RCC on 8/29/17 at 9:45 am revealed: -If a resident refused a supplement three times, the doctor would be notified. -This could be a refusal three times in one day or three consecutive days. -The MA completed the medication refusal form and fax that to the doctor or the MA could notify the RCC to notify the doctor. -The medication refusal form would then be filed in the resident's chart. Rreview of Resident #12's record revealed no medication refusal forms. Interview with the Administrator on 8/28/17 at 5:44 pm revealed: -Supplements were typically given three times daily. -This was done once the doctor gave the order. -The PCA's were expected to give shakes to residents as ordered. -The MA would then document that the shake was given. -PCA's were given a list of diabetic residents to reference when distributing snacks and supplements. -Resident #12 declined shakes at times. -This refusal was documented in the MAR by the RCC or MA. -The Administrator was unaware Resident #12 was supposed to receive shakes three times daily with a snack. Interview with the primary care physician (PCP) on 8/28/17 at 10:28 am revealed: -Resident #12's appetite went up and down. -Resident #12 sometimes would not eat if he did	D 310		

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D 310	Continued From page 91 not like the food. -The PCP believed the resident was declining mentally. -The PCP was aware of the resident's weight loss. -The PCP was not aware Resident #12 had not been getting supplements three times daily with a snack as prescribed. -The PCP expected Resident #12 to get the supplements when he put the order in place.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult 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 A2 VIOLATION Based on interviews and record review, the facility failed to assure 1 of 2 sampled resident (#6) was protected from assault and verbal abuse by Resident #5. The findings are: 1. Review of Resident #6's current FL-2 dated 10/17/16 revealed: -Diagnoses included Alzheimer's type dementia, altered mental state, hypertension, schizophrenia disorder, respiratory failure, thrombocytopenia, and intra-ventricular hemorrhage. -He was semi-ambulatory with a walker.	D 338		

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D 338	Continued From page 92 Review of Resident #6's Resident Register revealed; -Resident #6 was admitted to the facility on 6/28/1. -Resident #6 was his own responsible person. Review of Resident #6's care plan dated 10/14/16 revealed: -Resident #6 used a walker for mobility. -Resident #6 required limited assistance with eating, toileting, ambulation, and transferring. -Resident #6 required extensive assistance with bathing, dressing and grooming. Review of Resident #6 care progress notes revealed: -Resident #6 was spit on 3 times by another resident (#5) and verbally abused with racial slurs from the same resident on 5/5/17 (time was not specified). -Resident #6 was spit on by another resident (#5) on 6/24/17 (time was not specified) and Resident #6 hit the other resident with a walker. -Resident # 6 was walking down the hallway 7/12/17 and another resident (#5) stuck his foot to trip Resident #6 (time was not specified or if a fall occurred). -Resident #6 was verbally abused (name calling) and spit on by another resident (#5) on 7/23/17 (time was not specified). Interview with the Special Care Coordinator on 8/25/17 at 2:05pm revealed: -The staff in the Special Care Unit (SCU) just tried to keep Resident #5 away from the other residents when he acted out. -Resident #6 had been hit and spat on several times by Resident #5. -Resident #5 did not like Resident #6; she did not	D 338		

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D 338	Continued From page 93 know why. Interview with the Administrator on 8/25/17 at 4:30pm revealed: -Resident #5 did have a problem with hitting and spitting on other residents and staff in the SCU. -It did appear that Resident #5 had several more altercations with Resident #6 when compared to the other residents in the SCU. -She did not know what else could be done except for staff to keep the two residents separated. Interview with the Primary Care Provider (PCP) for Resident #5 on 8/28/17 at 10:20am revealed: -There was a history of Resident #5 hitting, spitting, and using racial slurs toward Resident #6. -The PCP said, "Resident #6 should know better and just avoid Resident #5". Confidential interview with a staff member revealed: -Resident #6 seemed to be a target for Resident #5. -The staff member did not know why Resident #5 did not seem to like Resident #6. -Staff tried to keep Resident #5 and Resident #6 apart. -If there was an altercation between Resident #5 and Resident #6, staff just tried to keep both residents calm. Interview with family member of Resident #6 on 8/29/17 at 11:10pm revealed: -Resident #6 had complained about Resident #5 hitting, spitting, cursing, and using racial slurs towards him several times. -Staff had called the family member every time something went on between Resident #6 and	D 338		

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	HAL046019	A. BUILDING: _____ B. WING _____	R 08/30/2017

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D 338	Continued From page 94	D 338		

Resident #5.
-The family member had advised Resident #6 to ignore Resident #5 but don't let Resident #5 spit on him.
-Resident #6 should be allowed to defend himself if Resident #5 was spitting.

Interview with Resident #6 on 8/29/17 at 4:20pm revealed:
-He did not bother any of the other residents in the Special Care Unit (SCU).
-He did not have a problem with Resident #5 because Resident #5 had a habit of punching, spitting and using racial slurs toward him several times.
-The staff had to separate Resident #5 and him several times because Resident #5 would get mad and start hitting and spitting at him.
-Resident #5 would started hitting and spitting at staff too.
-He had complained about Resident #5 several times to staff and staff did not do anything.
-The staff in the SCU told him to try to "stay out of Resident #5's way when Resident #5 started acting crazy".
-His PCP had told him to ignore Resident #5 because Resident 5 "didn't have good sense".
-He had tried to ignore Resident #5 because when he complained to the primary care provider about Resident #5 hitting and spitting on him and he needed to defend himself against Resident #5.
-The PCP threatened to send him to another facility if he hit Resident #5.

Interview with Resident #5 on 8/29/17 at 4:35pm revealed:
-He liked to keep to himself.
-He hit other residents if they got in his way.
-He could not specify who he had hit.
-He denied spitting, cursing, using racial slurs, or

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D 338	Continued From page 95 hitting staff. -He wanted to be left alone to watch television. The facility failed to protect Residents #6 from physical assault and verbal abuse by Resident #5 resulting in emotional distress. The facility's failure to protect the health, safety, and welfare of Resident #6 from Resident #5 constitutes a Type A2 violation for serious neglect. Review of the Facility's plan of protection dated for 8/25/17 revealed: -The Administrator will have staff members to continue to follow protocol to diffuse aggressive situation by immediately redirected residents if needed to ensure all residents are out of danger. -The aides if needed will call the primary care provider and family members to notify them of the situation. -The business office manager will contact the regional nurse immediately to schedule an inservice on residents' rights so all staff members will be aware and ensure the safety of the residents. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2017.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by:	D911		

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D911	Continued From page 96 FOLLOW-UP TO A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. TYPE B VIOLATION Based on interviews, the facility failed to assure four residents were treated with dignity and respect when spoken to by Staff D and Staff E. Interview with a resident on 8/25/17 at 4:07 pm revealed: -The staff could be hostile and often gossiped about residents. -He had witnessed Staff D making fun of a resident who smelled like urine and also cursing at him. -He did not share this with the administrator because he believed she was unapproachable. -He had also witnessed Staff E complaining about residents and saying she would curse at residents. -Staff E was often rude to residents when they asked for cigarettes. Interview with a second resident on 8/29/17 at 5:11 pm revealed: -Staff D "talked to people like dogs." -Staff D often yelled at residents. -Staff D did not like to work and got angry when asked to do something. Interview with a third resident on 8/29/17 at 5:20 pm revealed: -Staff D often cursed at residents. -He would curse at Staff D when she cursed at him. -He tried not to bother her to avoid confrontation.	D911		

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D911	Continued From page 97 Interview with a fourth resident on 8/29/17 at 5:24 pm revealed: -Staff D often had an attitude. -Staff D had never cursed at him but he did not bother her. -Staff D was easily set off by anything. Interview with a fifth resident on 8/29/17 at 5:27 pm revealed: -He had not had any problems with Staff D as he was usually polite to her. -He had witnessed her speaking harshly to another resident on several occasions in the dining room. -He did not think it bothered the resident and he had not told anyone. Interview with Staff D on 8/28/17 at 1:18 pm revealed: -She had not seen any staff person being rude or disrespectful to residents. -She had not been rude to any residents. -She did not curse at residents. -She got along with the residents in the facility. -She would not be working at the facility if she did not want to help people. -She stayed in the laundry room listening to music until a resident needed her. Interview with the Resident Care Coordinator on 8/29/17 at 8:21 am revealed: -She had not received any complaints from residents about the staff. -She talked with residents when going into the dining room. -Residents also came to her door to speak with her. -She did not do a regular walk through of the A hall.	D911		

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D911	Continued From page 98 Interview with the Administrator on 8/30/17 at 9:30 am revealed: -She expected staff to treat the residents as if they were their own grandparents. -She had not received any complaints from residents about staff. -She believed the residents would tell her if they were being mistreated. -She expected staff to assist residents even with tasks they were capable of doing on their own if they requested assistance. -She thought the residents often misunderstood what staff was saying to them. -She had not received any complaints about staff person D. -Staff E could get SCU residents to do things other staff could not. -She believed how Staff E talked and her character affected others' perception of her. The facility failed to ensure all residents were treated with dignity and respect and not spoken to harshly by Staff D and Staff E. The facility's failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility submitted a Plan of Protection dated 9/20/17, as follows: -Immediately, Staff E reviewed, dated and signed the resident's rights review. -Staff D no longer worked at the facility. -All staff will review, date and sign the resident's rights. -Staff will be inserviced by a Nurse on resident's rights on 10/11/17. -Staff will review resident's rights daily. -The Administrator, Resident Care Coordinator and the Special Care Unit Coordinator will assure resident's rights are reviewed weekly by staff.	D911		

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D911	Continued From page 99 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 15, 2017	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to housekeeping and furnishings and other requirements. The findings are: 1. Based on observations and interviews, the facility failed to assure that 2 of 3 halls free of unpleasant and offensive odors that spread through the entire Special Care Unit, the A Hall, the front sitting room, and dining room areas. [Refer to Tag D 075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings (Unabated Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116	D912		

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D912	Continued From page 100 degrees F for 12 of 12 water fixtures in the residents' bathrooms and the common hall shower room on the A Hall, C Hall, and Special Care Unit (SCU) [Refer to Tag D 0113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure residents were free neglect as related to staff qualifications, health care, and residents' rights. The findings are: 1. Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled (Staff F) had no substantiated findings listed on the Health Care Personal Registry prior to the date of hire and failed to perform a Health Care Personal Registry check for 1 of 2 sampled staff (Staff A) prior to the date of hire. [Refer to Tag D 0137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type A2 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to coordinate mental health services for 1 of 7 sampled residents (#5) with a documented history of physical aggression, being verbally abusive and displayed episodes of erratic behaviors. [Refer to Tag D 0273, 10A NCAC 13F .0902(b) Health Care (Type A2	D914		

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D914	Continued From page 101 Violation)]. 3. Based on interviews and record review, the facility failed to assure 1 of 2 sampled resident (#6) was protected from assault and verbal abuse by Resident #5.[Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to housekeeping and furnishings, staff requirements, health care, water temperatures, and residents' rights. 1. Based on observations and interviews, the facility failed to assure that 2 of 3 halls free of unpleasant and offensive odors that spread through the entire Special Care Unit, the A Hall, the front sitting room, and dining room areas. [Refer to Tag D 075, 10A NCAC 13F .0306(a)(2) Housekeeping and Furnishings (Unabated Type B Violation)]. 2. Based on observations, interviews and record	D980		

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D980	Continued From page 102	D980		

reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 12 of 12 water fixtures in the residents' bathrooms and the common hall shower room on the A Hall, C Hall, and Special Care Unit (SCU) [Refer to Tag D 0113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].

3. Based on interviews and record reviews, the facility failed to assure 1 of 2 sampled (Staff F) had no substantiated findings listed on the Health Care Personal Registry prior to the date of hire and failed to perform a Health Care Personal Registry check for 1 of 2 sampled staff (Staff A) prior to the date of hire. [Refer to Tag D 0137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications (Type A2 Violation)].

4. Based on observations, record reviews, and interviews, the facility failed to coordinate mental health services for 1 of 7 sampled residents (#5) with a documented history of physical aggression, being verbally abusive and displayed episodes of erratic behaviors. [Refer to Tag D 0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].

5. Based on interviews and record review, the facility failed to assure 1 of 2 sampled resident (#6) was protected from assault and verbal abuse by Resident #5.[Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).]

6. Based on interviews, the facility failed to assure four residents were treated with dignity and respect when spoken to by Staff D and Staff E. [Refer to Tag D 911 G.S. § 131D-21 (1) Declaration of Resident Rights (Type BViolation)]

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D980	Continued From page 103 The Administrator failed to assure the management, operations, and policies of the facility were implemented including implementation of residents' rights. The Administrator failed to assure residents were treated with respect and dignity as evidenced by keeping residents free of resident to resident abuse. The Administrator failed to assure appropriate care and services were provided by the failure to maintain substantial compliance with rules and statutes related to housekeeping and furnishings, staff requirements, health care, and water temperatures, which is the responsibility of the Administrator. This failure to implement rules and regulations resulted in the serious neglect to all residents which constitutes a Type A2 Violation. Review of the Plan of Protection dated 9/6/17 revealed: -The Administrator rechecked all housekeeping, kitchen, staffing checklists regarding the welfare, safety, and well-being of the residents on 9/6/17. -The Administrator will provide more implementation of these lists to ensure all residents are getting snacks as scheduled. -The Administrator will sign off on the cleaning checklists for the kitchen and housekeeping weekly to ensure all cleaning has been done. -The Administrator will continue to oversee all areas of care daily. -The department head will be responsible to ensure all tasks are carried out daily and the Administrator will recheck weekly all areas in the nursing, housekeeping, maintenance, and dietary departments and supervise as needed to ensure all tasks are being carried out accordingly and will continue to monitor daily and double check as needed.	D980		

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D980	Continued From page 104 CORRECTION DATE FOR THE A2 VIOLATION SHALL NOT EXCEED SEPTEMEBER 30, 2017.	D980		