STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on August 9-10, 2018.	{C 000}		
{C 074}	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls in four residents' rooms; the ceiling vents in three resident bathrooms; the floors in the short hallway, the hallway leading to the residents' rooms, the common bathroom, the living room, the dining room, and four residents' rooms; and the exterior door in the hallway leading to the residents' rooms were kept clean and in good repair. The findings are: Observation of the living room and small hallway on 08/09/18 at 9:20am revealed: -There was an area approximately 8 feet in length with multiple tiles that were stained a gray colored irregular curved type pattern on the floor located in front of the doorway to the dining room that extended into a small hallway on the right side of the living room. -There was a gray colored stain that was approximately 3 feet long on the floor in front of a chair in the living room.	{C 074}		

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{C 074}	Continued From page 1 -There was a gray colored stain that was approximately 3 inches long and 2 inches wide on the floor at the entrance to the hallway leading to residents' rooms. Observation of the last resident room on the right side of the hallway (room #2) on 08/09/18 at 10:00am revealed: -There were scattered rust colored stains on the floor beside of a nightstand located on the left side of the bedroom entrance. -There were approximately 10 square floor tiles with multiple scratches and a worn surface that exposed the floor's dull gray color under layer surface. -There were 6 - 10 floor tiles with a gray colored irregular shaped stain on the floor in front of the closet door and dresser. -There were multiple floor tiles that were discolored gray and were scratched along the edges of the floor under the window. Interview with the live-in PCA on 08/09/18 at 9:40am revealed: -The spots on the living room, hallways, and dining room floors had been there since she started working at the facility in February 2018. -She had tried to clean the spots up when she mopped but the spots would not come up. -The spots looked like paint thinner had been spilled and would probably come up with buffing the floor. -She had not tried buffing the spotted areas on the floors. -She had been asked by the Administrator where the spots had come from. -Her duties included cleaning the facility. -The facility did not have a written deep cleaning schedule. -She performed deep cleaning every week which	{C 074}		

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{C 074}	Continued From page 2 included cleaning out closets, window seals and cleaning the windows. Interview with the Administrator on 08/10/18 at 10:30am revealed: -The spots on the living room, dining room, and hallways floors had been there about 6 months. -Nobody could tell her where the spots came from. -Staff had tried scrubbing the spots with bleach and cleaning supplies. -She was going to try to get the floors buffed. Observation of the hallway leading to the residents' rooms on 08/09/18 at 9:45am revealed: -There was an exterior door at the end of the hallway with small scattered indented areas and missing white paint that exposed the door's dull gray color under layer surface. -There was a broken floor tile, exposing the sub-floor, at the end of the hallway. Interview with the Administrator on 08/10/18 at 10:40am revealed: -She had not noticed the cracked tile by the hall exit door. -She would get maintenance staff to check the cracked floor tile. -The maintenance staff came to the facility as needed to do "major construction". -If there was something simple like changing a light bulb, the staff did that. -The rubbed areas on the exit door were from wheelchairs. -The paint needed to be touched up. -There might need to be some attention given to the cracked floor tile at the exit door. Observation of the ceiling in the bathroom between room #1 and #2 on 08/09/18 at 10:22am	{C 074}		

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{C 074}	Continued From page 3 revealed: -There was a rusted air vent cover over the sink. -There were numerous specks of a loose substance inside the light globe attached to the ceiling. The specks of loose substance had the appearance of dead insects. -The vent to the right of the light globe was covered with a heavy layer of dust. Observation of the bathroom between the first and second rooms on the left side of the hall (rooms #3 and #4) on 08/09/18 at 10:27am revealed: -The toilet tissue cover was missing from the toilet tissue holder and the toilet tissue was sitting on the window ledge across from the toilet. -There was a rusted ceiling vent cover over the bathroom sink. -The vent cover next to the ceiling light fixture was covered with dust. Observation of the last resident room (#6) on the left of the hallway on 08/09/18 at 10:40am revealed: -There was a build-up of yellow and brown colored stains and debris approximately one foot from the wall along all of the edges of the floor with a heavy concentration under and around the bed, nightstand, chest of drawers, and chair sitting in the corner of the room. -The closet room door had scattered, brown, grimy marks around the door handle. -There were scattered brown colored marks on the walls throughout the room. -The black rubber baseboard covering was detached from the wall along the back wall and right side of the room. Interview with the Administrator on 08/10/18 at 10:45am revealed:	{C 074}		

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{C 074}	Continued From page 4	{C 074}		

-The baseboard covering detached from the wall in resident room #6 would need to be fixed by maintenance staff.
-She did not know how long the baseboard had been detached from the wall.

Attempted interview with the resident assigned to resident room #6 on 08/09/18 at 9:00am was unsuccessful.

Interview with the Supervisor on 08/09/18 at 9:20am revealed:
-All live-in personal care aides (PCAs) were assigned cleaning duties for two residents' rooms each shift they were assigned to work.
-All staff had to clean the bathrooms and living room every day.
-All staff were supposed to check the resident bathrooms daily and remove any trash.

Interview with the Administrator on 08/10/18 at 10:35am revealed:
-The rusted vents were on the list for maintenance staff to fix.
-Moisture caused the rust.
-The scales had been in the bathroom forever and she had never paid attention to them.

Interview with the Administrator on 08/10/18 at 10:50am revealed:
-She and the Supervisor were supposed to do walkthroughs of the facility weekly.
-She had not asked the Supervisor about her walkthroughs.
-She did not know the last time the Supervisor had performed a walkthrough of the facility.
-Any issues that required the maintenance staff had to be done based on his schedule.
-When she did a walkthrough of the facility 3 weeks ago, she noticed some cleaning was

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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{C 074}	Continued From page 5 needed which was discussed with staff. -There were no documented walkthroughs of the facility. -The live-In PCAs had assigned resident rooms to deep clean. -Deep cleaning consisted of cleaning ceiling fans, wiping down blinds and window seals. -The PCAs were supposed to deep clean assigned rooms at least once a shift when they worked. -When she walked through the facility, she walked in every room and focused on cleanliness. -Sometimes she looked behind the beds and chairs to see what condition things were in.	{C 074}		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by a hard pebble-like substance on the floor of the shower stall used by the residents, a glass mirror detached and unsecure leaning against the wall on the resident bathroom sink, and a rusted resident scale in the bathroom.	C 078		

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B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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C 078	Continued From page 6 The findings are: 1. Observation of the common bathroom on 08/09/18 at 10:05am revealed: -There was a heavy grayish-black substance around the back and right side of the shower where the wall met the floor. -There were multiple scattered grayish-black irregular shaped particles of different sizes scattered on the floor of the shower. -The same grayish-black hard type material covered the edges of the tiled floor between the bathtub and outer wall of the shower stall and extended approximately 4 inches up the wall. Interview with the live-In Personal Care Aide (PCA) on 08/09/18 at 10:07am revealed: -The black colored substance in the shower stall was paint. -Someone had sprayed some paint over cement that was put down in the shower stall. -The loose particles on the shower floor were chips from the cement. Observation of the PCA on 08/09/18 at 10:07am revealed: -She rubbed her shoe covered foot over the grayish-black raised area in the shower stall. -Small pieces of the grayish-black substance detached from the area creating more small hard pebble-like substances. Continued interview with the PCA on 08/09/18 at 10:17am revealed: -The shower floor had been like that since she started working at the facility. -The residents used the shower to bathe. -If the residents stepped on the hard pebble-like substances, it could hurt their feet.	C 078		

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C 078	Continued From page 7 Interview with a resident on 08/09/18 at 10:30am revealed the grayish-black stuff on the shower floor was where the wall had been patched about 4 or 5 months ago. Interview with a second resident on 08/09/18 at 10:35am revealed: -He used the shower to bathe. -The black stuff on the shower floor was tar that had been there since he came there. -He had been living at the facility for "almost 2 years". -He had not stepped on the hard pebble-like substance on the shower stall floor. Interview with a third resident on 08/09/18 at 4:10pm revealed: -When he took showers, he had stepped on some of the "little rocks" in the shower. -He liked to shower every day. -He last took a shower on 08/08/18. -It felt like he was stepping on a rock when he stepped on the grayish-black pebble-like substance in the shower. -He had not cut his feet or anything from stepping on the pebbles. -There was a hole in the wall and someone called themselves fixing it, but they did not. -The shower stall floor had been like it was now for about 2 months. Interview with the Administrator on 08/09/18 at 4:17pm revealed: -The common bathroom shower was an ongoing project. -There had been other maintenance projects that had to be done. -She was financially trying to get housekeeping things done.	C 078		

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B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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C 078	Continued From page 8 -The shower was the next thing on her list to get fixed. -The shower had been like it was for at least 6 months. -No one had complained to her about the shower. -She did not recall if anyone had mentioned about the sealant sloughing off. -The tile was leaking so a sealant was put on to stop the leak. -There was only one shower in the facility that the residents used. Interview with the Administrator on 08/10/18 at 10:33am revealed: -Someone was supposed to come next week to start working on the shower. -The maintenance staff told her the whole shower needed to be retiled. -The black loose spots on the shower stall floor felt like pebbles. -No one had ever mentioned the shower stall floor to her and she had never paid any attention to the pebbles. -Most of the time the residents would sit in the shower chair and the area where their feet were did not appear to have a lot of pebbles. Refer to interview with the Administrator on 08/10/18 at 10:50am. 2. Observation of the common bathroom on 08/09/18 at 10:05am revealed there was a stand up scale between the bathtub and shower stall of which the base was covered with rust. Interview with the live-in PCA on 08/09/18 at 10:17am revealed: -The Supervisor (named) weighed the residents. -She had never used the scale. -Staff knew the scale was rusted.	C 078		

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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C 078	Continued From page 9 -Sometimes if you hit the base of the scale with the mop, brown flakes would fall off on the floor. Observation of the PCA on 08/09/18 at 10:17am revealed she touched the top of the scale and peeled back a piece of the brown rusted substance by gently putting her hand at the edge of the rusted substance and slightly lifting it backwards. Interview with a resident on 08/09/18 at 10:35am revealed: -He had noticed the rusted scale. -He was weighed on the scale about every two weeks by the Supervisor. -He would step on the scale with his shoes on. Interview with the Administrator on 08/10/18 at 10:35am revealed: -The scales had been in the resident bathroom "forever". -She had never paid close attention to the scales. -The scales had not worked since she had been at the facility. Refer to interview with the Administrator on 08/10/18 at 10:50am. 3. Observation of the bathroom between resident rooms #1 and #2 on 08/09/18 at 10:22am revealed: -There was a square glass mirror propped on the ledge of the sink behind the water fixture. -There was a portion of the wall above the sink that was a lighter color than the rest of the wall that was the same size of the mirrored glass. There were nails in the wall surrounding the light colored portion of the wall. Interview with the Supervisor on 08/09/18 at	C 078		

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B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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C 078	Continued From page 10 11:05am revealed: -She did not know the bathroom mirror was off the wall. -If the mirror had broken, the resident in bedroom #2 could get cut. -There was no resident currently living in bedroom #1. Observation of the Supervisor on 08/09/18 at 11:05am revealed she removed the mirror from the bathroom. Refer to interview with the Administrator on 08/10/18 at 10:50am. _____ Interview with the Administrator on 08/10/18 at 10:50am revealed: -She and the Supervisor were supposed to do walkthroughs of the facility weekly. -She had not asked the Supervisor about her walkthroughs. -Any issues that required the maintenance staff had to be done based on his schedule. -When she did a walkthrough of the facility 3 weeks ago, she noticed some cleaning was needed. -She did not know the last time the Supervisor had performed a walkthrough of the facility. -There were no documented walkthroughs of the facility. _____ The facility failed to assure the floor of the only shower available for use by residents was free of a hard pebble-like substance that was stepped on by the residents when showering, which was a potential hazard for injuries. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in	C 078		

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

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C 078	Continued From page 11 accordance with G.S. 131D-34 on 08/10/18 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2018.	C 078		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the smoke detector in the dining room and electrical outlet covers in 2 resident rooms were maintained in a safe and operating condition. The findings are: 1. Observation of the facility on 08/09/18 at 9:05am revealed an intermittent chirping sound was heard throughout the facility that continued throughout the morning. Interview with the Supervisor on 08/09/18 at 9:10am revealed: -She had not noticed the chirping sound in the facility. -The sound was probably a battery in the smoke	C 102		

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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C 102	Continued From page 12 detector that needed to be replaced. Observation of the Supervisor on 08/09/18 at 12:30pm revealed: -She was seated in the living room when the chirping sounded. -The Supervisor did not pay any attention to the chirping sound. Observation of a staff on 08/09/18 at 12:40pm revealed the staff removed the cover from the dining room smoke detector and changed the battery. The chirping sound immediately stopped. Interview with the staff on 08/09/18 at 12:40pm revealed: -She and the live-in PCA had noticed the chirping sound yesterday and were going to get it fixed. -She had not mentioned to anyone that she had heard the chirping sound in the facility. -She thought the maintenance staff should be responsible to change the smoke detector batteries. -She did not really know the last time she had seen the maintenance staff there. Interview with a resident on 08/09/18 at 4:30pm revealed: -He had heard the chirping sound on and off as long as he had been at the facility, and he had been at the facility for 3 years. -He heard the chirping sound last night. -He thought the chirping sound was coming from the end of the hall. -He had not heard the chirping sound since after lunch on 08/09/18. Interview with the Administrator on 08/09/18 at 4:15pm revealed:	C 102		

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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C 102	Continued From page 13 -She had noticed a chirping noise in the dining room from time to time. -When the chirping sound was noticed, it meant the batteries in the smoke detector needed to be changed. -There was no schedule for checking the smoke detector batteries. Observation of the last resident room (#2) on the right side of the hallway on 08/09/18 at 10:00am revealed there was a broken electrical outlet cover on a two socket electrical wall plug located under the window. Interview with the resident in room #2 on 08/09/18 at 3:55pm revealed: -The outlet cover had been broken about 1 - 2 months. -He had not mentioned it to anyone. -It was his fault that it was broken because he had hit the outlet cover with his wheelchair. Observation of the next to last resident bedroom (#1) on the right side of the hallway on 08/09/18 at 10:20am revealed: -There was a broken electrical outlet cover on a two socket wall plug located on the wall behind the head of the bed with the interior of the wall exposed around the corners of the two socket electrical wall plug. -There was a small piece of wood, hanging from a cord attached to a metal plate, that rested on the wall at the level of the broken electrical outlet cover about two inches from the corner of the broken electrical cover. Interview with the Administrator on 08/09/18 at 4:16pm revealed: -The electrical outlet covers had been replaced a couple times.	C 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 102	Continued From page 14 -She was not aware of the broken outlets covers. -She normally did a walkthrough of the facility every week. -She was in and out of the facility last week but did not look at everything like she normally did. -Her last thorough walkthrough in the facility was week before last.	C 102		
{C 284}	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family 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 assure a physician's ordered therapeutic diet of chopped meats and no added salt was served to 1 of 3 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL-2 dated 12/04/2017 revealed: -Diagnoses included hypertension, cerebrovascular accident, tobacco use, and severe alcohol use history. -A physician's order for a no added salt diet. Review of a diet order for Resident #2 dated 02/22/2018 revealed a physician's order for a no added salt with chopped meats diet. Review of the diet list posted on front of the	{C 284}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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{C 284}	Continued From page 15 refrigerator door in the kitchen revealed Resident #2 was on a no added salt, chopped meats diet. Review of the therapeutic diet spreadsheet lunch menu for Thursday of Week One posted in the kitchen on 08/09/2018 revealed Resident #2 was supposed to be served 3 ounces (oz) of chopped beef steak. Observation of the Live-In PCA on 08/09/2018 at 12:00pm who prepared the lunch meal revealed: -Resident #2's meal was plated in the kitchen and placed on the dining room table by the Live-In PCA. -The plated food included a whole beef patty served with a brown gravy covering. Observation of Resident #2 in the dining room from 12:00pm to 12:13pm revealed: -The resident coughed twice as he sat at the table drinking his liquids. -The resident did not eat any of the meat. -Resident #2 gave his beef patty to another resident. Interview with the Live-In PCA on 08/09/2018 at 12:24pm revealed: -Resident #2 was supposed to get chopped meats. -Resident #2 was not a big eater. -She noticed Resident #2 stopped eating and wondered if the resident stopped eating because he was coughing. Interview with the Live-In PCA on 08/09/2018 at 3:40pm revealed: -She served each food item on all the resident plates before serving the second food item on the plates. -She knew what each resident was supposed to	{C 284}		

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B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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{C 284}	Continued From page 16	{C 284}		

be served because she worked at the facility and everybody ate "pretty much the same thing."
-There was a list of diets posted on the refrigerator of what each resident was supposed to be served.
-She had not used the diet list today (08/09/2018) when she served Resident #2's lunch meal.
-She did not think to use the diet list today (08/09/2018).
-She had "glimpsed over" the diet list on the evening of 08/08/2018.
-She thought about chopping Resident #2's meat earlier in the day but still forgot to chop Resident #2's meat before serving the meal.
-Resident #2 coughed often.
-She noticed Resident #2 coughed more at night and when he was eating.
-She did not know what caused Resident #2 to cough.

Interview with the Resident Care Coordinator (RCC) on 08/09/2018 at 2:15pm revealed:
-Resident #2 had a barium swallow done to clarify the resident's diet order.
-She received the results of the barium swallow on 07/24/2018.
-She had not heard from the Primary Care Provider (PCP) of any changes in Resident #2's diet.
-As far as she knew, Resident #2 was prescribed a no added salt chopped meats diet.

Interview with Resident #2 on 08/09/2018 at 4:30pm revealed:
-Sometimes he did not want to eat lunch.
-He ate when he wanted to eat.
-He coughed sometimes.

Interview with the Administrator on 08/10/2018 at 11:00am revealed:

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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{C 284}	Continued From page 17 -She had not spoken to Resident #2's PCP about the results of the barium swallow that was ordered for clarification of Resident #2's diet order. -The facility was waiting to hear back from the PCP as to whether Resident #2's meats needed to be chopped. -Resident #2's current diet order was for chopped meats. -She expected staff to "cut up" Resident #2's meats. -The RCC had informed her on 08/09/2018 that the Live-In staff had not served Resident #2's chopped meats for lunch on 08/09/2018. -She would check the fax machine to see if the PCP had sent any information on Resident #2's diet order. Observation of the lunch meal served to Resident #2 on 08/10/2018 at 11:50am revealed: -The resident's plated food included pork meat cut in small pieces. -The resident ate 3/4th of the meat portion served. -The resident did not cough during the lunch meal. Interview with the Administrator on 08/10/2018 at 12:20pm revealed when the RCC told her yesterday (08/09/2018) about the staff not serving Resident #2 chopped meats at lunch, she (administrator) instructed the RCC to call the PCP about the diet order.	{C 284}		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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{C 330}	Continued From page 18	{C 330}		

preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

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

Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 3 residents (Resident #1) sampled with orders for medications used to treat diabetes and breathing disorders.

The findings are:

Review of Resident #1's current FL-2 dated 01/29/18 revealed diagnoses included schizoaffective disorder, diabetes mellitus, gastro-esophageal reflux disease, hypertension, hypothyroidism, and hyperlipidemia.

1. Review of physician's orders for Resident #1 revealed:
-There was a physician's order dated 01/29/18 on the current FL-2 for metformin (used to lower blood glucose) 1000mg tablet twice daily.
-There was a subsequent physician's order dated 04/19/2018 for metformin 500mg tablet daily.
-There was a physician's order dated 01/29/18 on the current FL-2 for finger stick blood sugar (FSBS) testing daily.

Review of a Nurse Practitioner (NP) visit note dated 07/31/18 revealed the NP wrote "consider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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{C 330}	Continued From page 19 d/c [discontinue] metformin." Review of the August 2018 Medication Administration Records (MAR) for Resident #1 revealed: -There was a printed entry for metformin 500mg take one tablet once daily scheduled for administration at 8am. -"D/C" was handwritten in the section of the MAR for documenting administration for the metformin.There was no date or staff initials for the "D/C" notation to the MAR. -There was no documentation for administration of metformin 500mg tablet every day from 08/01/18 through 08/10/18. Observation of the medication on hand on 08/10/18 at 9:20am with the medication aide (MA) revealed there was no metformin 500mg tablets on hand for Resident #1. Review of documented FSBS results for Resident #1 revealed the resident's FSBS's ranged from 109 to 231 from 08/01/18 - 08/10/18. Interview with the MA on 08/10/18 at 9:35am revealed: -There was no metformin on hand for Resident #1. -The MAR documentation reflected the metformin had been discontinued. -She administered medications to Resident #1 this morning. -She administered medications according to instructions printed on the MAR. -The Resident Care Coordinator (RCC) was responsible for transcribing orders to the MAR. Interview with the Administrator on 08/10/18 at 9:40am revealed:	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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{C 330}	Continued From page 20 -She had just reviewed the metformin order dated 07/31/18. -The metformin for Resident #1 was discontinued on 07/31/18. -The NP wrote the order on 07/31/18 to "consider" discontinuing the metformin for Resident #1. -There was no order to discontinue the metformin. -The last documented administration for the metformin was on 07/31/18 at 8:00am. -She was not sure how the RCC determined to discontinue the metformin unless she did not see the word "consider". Interview with the Provider Pharmacy Representative on 08/10/18 at 12:40pm revealed: -The provider pharmacy printed the facility MAR which were delivered to the facility around the 25th of the current month for the upcoming month. -The facility staff was responsible for transcribing to the MAR any new orders received after the MAR was delivered and the new orders would be printed on the MAR when they were next printed. -There was a current order dated 04/19/18 for metformin 500mg tablet daily in the pharmacy profile for Resident #1. -The pharmacy provider dispensed a quantity of 30 tablets for a 30 day supply of the metformin 500mg tablets to the facility for Resident #1 on 04/20/18, 05/17/18, 06/14/18, and 07/16/18. -He would be sending metformin 500mg one tablet daily to the facility on 08/10/18. -He did not know if there had been any metformin 500mg tablets returned to the pharmacy for Resident #1 and would have to look into that. -The pharmacy had received the order dated 04/19/18 indicating "consider" discontinuing the metformin but the medication was not	{C 330}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 330}	Continued From page 21	{C 330}		

discontinued at the pharmacy because the order was not specific.
-He did not know if the pharmacy reached out to the facility or provider about the way the order was written.

Interview with the Administrator on 08/10/18 at 1:07pm revealed:
-She spoke with the NP's nurse earlier this morning and was informed the metformin 500mg tablet daily was not supposed to have been discontinued.
-She contacted the provider pharmacy, after speaking to the NP's nurse, to reorder the metformin.

Interview with the NP on 08/10/18 at 1:25pm revealed:
-She was not aware Resident #1 had not been administered the metformin 500mg tablet as ordered.
-She had not given an order to discontinue the metformin.
-She was considering discontinuing the metformin but wanted to check labs on Resident #1.
-Resident #1's A1C (a blood test that reflects the average blood glucose level over a period of time) labs were improving.

Refer to the interview with the Administrator dated 08/10/18 at 9:45am.

2. Review of physician's orders for Resident #1 revealed:
-There was a physician's order dated 01/29/18 on the current FL-2 for QVAR (used to treat upper respiratory disease) 40mcg - inhale one puff twice daily.
-There was a subsequent physician's order dated

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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{C 330}	Continued From page 22 06/26/18 for QVAR Redihaler 80mcg two puffs twice daily. Review of the June 2018 MAR for Resident #1 revealed: -There was documentation of administration for QVAR 40mcg inhale one puff twice daily from 06/01/18 through 06/30/18 scheduled for 8am and 5pm. -There were no printed or handwritten instructions to the MAR for QVAR 80mcg inhale 2 puffs twice daily. -There was no documentation of administration for QVAR 80mcg inhale 2 puffs twice daily from 06/27/18 through 06/30/18 as ordered by the licensed prescribing practitioner. Review of the July 2018 MAR for Resident #1 revealed: -There was a printed entry on the MARs for QVAR 40mcg inhale one puff twice daily. -There was a single diagonal line drawn across the printed instructions for the QVAR 40mcg inhaler with "Rx [prescription] changed" handwritten in the section for documentation for medication administration. -There was no documentation of administration for QVAR 40mcg inhale one puff twice daily. -There were no printed or handwritten instructions to the MAR for QVAR 80mcg inhale 2 puffs twice daily. -There was no documentation of administration for QVAR 80mcg inhale 2 puffs twice daily. Review of the August 2018 MAR for Resident #1 revealed there was documentation of administration for the QVAR 80mcg inhale 2 puffs twice daily to Resident #1 at 8am and 8pm, beginning on 08/01/18.	{C 330}		

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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{C 330}	Continued From page 23 Observation of the medication on hand on 08/10/18 at 9:20am with the medication aide (MA) revealed the QVAR 80mcg inhaler was on hand with a pharmacy labelled instructions for two puffs twice daily and dispensed on 07/26/18. Interview with the MA on 08/10/18 at 9:35am revealed: -She had administered the QVAR 80mcg inhaler two puffs to Resident #1 this morning. -She administered medications according to instructions printed on the MAR. -The RCC was responsible for transcribing orders to the MAR. Interview with the Provider Pharmacy Representative on 08/10/18 at 12:50pm revealed: -There was a current order for QVAR 80mcg two puffs twice daily written 06/26/18 and received in the pharmacy on 06/26/18 via electronic script from the provider. -The QVAR 80mcg inhaler was dispensed to the facility on 06/27/18 and 07/27/18, each with 120 doses for a 30 day supply. -The QVAR inhaler was used to open up the airway for patients with "bad" respiratory disorders. Interview with the NP on 08/10/18 at 1:25pm revealed: -She was concerned when medications were not administered as ordered. -Resident #1 had not had any respiratory flare ups that she was aware of. -Resident #1 had not been in the hospital for any breathing problems. -She had not received any calls that Resident #1 had any difficulty breathing. Interview with Resident #1 on 08/10/18 at 1:15pm	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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B & B ASSISTED LIVING # 2	2610 HWY 130 WEST ROWLAND, NC 28383

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{C 330}	Continued From page 24 revealed: -He could not remember if he had received his inhaler in July 2018. -He had some problems with breathing about 3 or 4 days ago when he felt like he could not breathe. -When he had the feeling like he could not breathe, it felt like his "wind was going away." -He did not tell anybody and did not do anything when he felt short of breath. -He did not remember feeling like he could not breathe in July 2018. -He did not know the names of medications he was administered. -The MAs administered his medications to him. Refer to interview with the Administrator dated 08/10/18 at 9:45am. _____ Interview with the Administrator on 08/10/18 at 9:45am revealed: -Normally the MAs went by the provider orders to transcribe new orders to the MAR. -A new system was implemented in January 2018 where she reviewed all provider orders that came to the facility to ensure the orders were transcribed to the MAR correctly and that the medication was on hand. -She had not had the time to review the 07/31/18 orders written by the NP. -The NP orders had been placed in the resident's record before she had the time to review them. -She was not sure why the plan was not followed with the 07/31/18 orders. _____ The facility failed to administer medication as ordered to Resident #1, who had a history of diabetes and was ordered an antidiabetic medication, for ten cosecutive days; and a medication used to treat breathing disorders for four days in June 2018 and the month of July	{C 330}		

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	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 330}	Continued From page 25 2018, to Resident #1 who experienced shortness of breath for 4 days in June 2018. The facility's failure was detrimental to the health and well-being of the resident and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/18 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2018.	{C 330}		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure each resident received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration and housekeeping and furnishings. The findings are: 1. Based on observations and interviews, the facility failed to assure the facility was free of hazards as evidenced by a hard pebble-like substance on the floor of the shower stall used by	C 912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078103	A. BUILDING: _____ B. WING _____	R 08/10/2018

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

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C 912	Continued From page 26 the residents, a glass mirror detached and unsecure leaning against the wall on the resident bathroom sink, and a rusted resident scale in the bathroom. [Refer to Tag 078, 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 1 of 3 residents (Resident #1) sampled with orders for medications used to treat diabetes and breathing disorders. [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 912		