STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078097	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B & B ASSISTED LIVING # 6	2133 PRESTON ROAD MAXTON, NC 28364

(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 and the Robeson County Department of Social Services conducted an annual survey on 06/30/21.	C 000		
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: Based on observations, record reviews, and interviews, the facility failed to maintain an uncluttered and free from obstructions and hazards environment related to unsecured oxygen cylinders. The findings are: Observation of a private occupied resident room on 06/30/21 at 8:48am revealed: -There was no signage on the door indicating the use of oxygen (O2). -There were five unsecured O2 cylinders that were 25 1/2 inches in length sitting upright on the floor in front of the closet door. -There was no rack or crate in the room to hold the oxygen cylinders. Observation of a private unoccupied resident	C 078		

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C 078	Continued From page 1 room on 06/30/21 at 8:57am revealed: -There was no signage on the door indicating the storage of O2 cylinders. -There were six unsecured empty O2 cylinders that were 25 1/2 inches length sitting upright on the floor in front of the closet door. -There was a storage stand in the room in front of the O2 cylinders which would hold 6 cylinders, but was empty of any cylinders. Interview with a personal care aide (PCA) on 06/30/21 at 9:40am revealed: -The resident received services from home health and had just returned from the hospital last night (06/29/21). -The resident had O2 ordered and delivered to the facility. -The oxygen was delivered by home health services, but they did not leave a rack to store the O2 cylinders. -The facility did not have a designated storage area for the O2. -The O2 cylinders in the unoccupied resident room belonged to a previous resident who was no longer at the facility. -Those cylinders were delivered by hospice for the resident when he resided at the facility. -The facility had contacted hospice several times to come pick up the cylinders within the last month since the resident expired. -The staff were not allowed to lock the door to the room as they did not have a key to open the door. -She did not realize the O2 tanks had to be kept in the rack but would put them in it. Interview with a medication aide (MA) on 06/30/21 at 2:45pm revealed: -Hospice delivered O2 several time to the resident who formerly resided at the facility but was unsure of the exact dates.	C 078		

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C 078	Continued From page 2 -She had not seen an O2 cylinder storage rack in the unoccupied resident room. -She had not reported the unsecured O2 cylinder to other staff or management of the facility. -Management of the facility had contacted the agencies to come pick up the O2 cylinders within the last month since the resident had expired. Interview with the Resident Care Coordinator (RCC) on 06/30/21 at 9:27am revealed: -She knew O2 cylinders were delivered to the facility for the resident when he resided at the facility. -The current resident had just returned to the facility last night from the hospital (06/29/21) with his O2. -She was aware O2 cylinders were unsecured in the unoccupied resident room. -She thought all the O2 cylinders were stored in the closet of the unoccupied resident room. -She thought a rack or crate to store the O2 cylinders was supposed to be delivered with the O2 cylinders. -She had requested racks to be delivered from both the home health and hospice agencies who delivered the O2 cylinders when they delivered the O2 cylinders did not remember the exact dates. -She also requested that the agencies come pick up their empty O2 cylinders currently on hand but could not remember the exact dates. -She had not documented the calls to the agencies when she requested them to pick up their O2 cylinders, but she would from now on. -She was concerned that the O2 cylinders were unsecured in the unoccupied resident room since the resident had expired and were risk of being bumped. -She expected staff to place the O2 cylinders into a closet for storage and to use the storage racks	C 078		

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C 078	Continued From page 3	C 078		

when made available.
-She would locate crates or other storage devices to secure the O2 cylinders and have all O2 cylinders placed in the closet in the unoccupied resident room, except the one the current resident had in use, until the agencies came to pick them up from the facility.

Telephone interview with the Administrator on 06/30/21 at 4:30pm revealed:
-She knew the resident had received O2 cylinders to administer O2 when he resided at the facility.
-She expected staff to contact the agencies to pick up the empty O2 cylinders.
-She thought the RCC had contacted both agencies to come pick up the empty O2 cylinders.
-She thought O2 cylinders always needed to be kept away from hazards.
-She did not know there were unsecured O2 cylinders in the facility.
-The RCC was responsible for ensuring O2 cylinders were stored securely in a rack or crate.

Telephone interview with the hospice agency staff on 06/30/21 at 4:45pm revealed:
-He was not contacted to come pick up the O2 cylinders from the facility.
-The agency was unable to pick up the O2 cylinder from the facility as he did not have the address.
-The agency had delivered O2 to the facility and then referenced it by the former name.
-The old facility sign was still posted in the facility roadway entrance and the address remained the same.
-The agency had delivered O2 cylinders to the facility for the former resident.
-The agency did not provide storage racks for the cylinders.
-He had put in a request for the pick-up of the O2

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C 078	Continued From page 4 cylinders and would provide storage racks for any future deliveries for the facility. Based on observations, interviews, and record review, it was determined the current resident residing at the facility was not interviewable.	C 078		