Received via email on 07/27/21

PRINTED: 07/01/2021
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035029	A. BUILDING: _____ B. WING _____	R 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER HEALTHCARE #2	113 JUSTICE STREET LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 16, 2021.	C 000	The black spots on the upper portion of the bathroom #1 has been cleaned and the spots has not reappeared. The bathroom will be maintained with adequate ventilation to prevent reappearance in the future. The ~~administrator~~ administrator will ensure that proper house keeping and proper maintained in Bathroom #1	
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 ensure the walls and ceiling of 1 of 2 residents' bathrooms (#1) were kept clean and in good repair. The findings are: Observation of the resident bathroom #1 on 06/16/21 at 8:07am revealed: -There were black spots along three sides of the beam extending from the middle portion of the ceiling. -There were black spots along the upper portion of the tiled wall above the bathroom doorway. -There were black spots along the upper wall to the left and right of the bathroom ceiling vent. -There were black spots along the upper portion of the wall to the right of the bathroom sink that extended approximately 12 inches down the wall.	C 074		

Correction date- 07/31/21-
SS- 8/2/21

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BRIDGET DuRue — TITLE: Administrator — (X6) DATE: 7/14/21

Reviewed and acknowledged with revisions-
SS- 8/2/21

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C 074	Continued From page 1 Interview with a resident on 06/16/21 at 8:07am revealed: -He was legally blind but cleaned the bathroom to the best of his ability. -He and the other residents used bathroom #1 more than bathroom #2. Interview with another resident on 06/16/21 at 11:15am revealed: -The walls and ceiling of bathroom #1 were like that when he moved in last year in 2020. -He used bathroom #1 frequently like the other residents. -The staff used the other bathroom to shower. Interview with the Administrator on 06/16/21 at 12:43pm revealed: -She had not noticed the black spots on the upper walls and ceiling of bathroom #1 until today, on 06/16/21. -She encouraged the residents to leave the bathroom door opened after showering because the bathroom did not have a window to allow ventilation. -She thought the black spots were caused by moisture in the bathroom. Telephone interview with a Supervisor in Charge (SIC) on 06/16/21 at 1:38pm revealed: -She knew there were black spots on the upper walls and ceiling of bathroom #1. -She thought the black spots were mildew. -The black spots appeared because something was broken in bathroom #1. -She could not remember what was broken in bathroom, but she told the Administrator. -She recalled the plumber came to the facility in May 2021 to repair something in bathroom #1, but she did not recall what he repaired.	C 074		

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C 074	Continued From page 2 Telephone interview with the Administrator on 06/16/21 at 2:43pm revealed: -She had a plumber and electrician to come to the facility in May 2021 to replace toilets and install lights. -She was not at the facility daily, but conducted a monthly inspection of the facility. -Staff had not made her aware of the black spots on the upper walls and ceiling. -If she knew about the black spots, she would have addressed it. -She was responsible for ensuring the walls and ceilings of the facility were clean and in good repair.	C 074	The hot water temperature has been maintained to normal range of 100°F to 116°F. The water temperature adjustment was made immediately and is now within normal range. The administrator will ensure that the water temperature will be maintained within normal range of 100°F to 116°F. The correct log will be maintained accurately.	
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. 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 is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimal of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 3 of 3 fixtures at two sinks, and one shower for residents. The findings are: Review of the facility's water temperature log	C 105	Correction date- 07/31/21- SS- 8/2/21	

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C 105	Continued From page 3 revealed: -The water temperature logs were stored in a plastic sleeve attached to the refrigerator in the kitchen. -The water temperatures were for the kitchen sink fixture and both residents' bathroom fixtures. -The residents' bathrooms were distinguished as "pink bathroom" and "hallway bathroom". -The water temperature logs did not indicate which resident bathroom fixtures were used to test the temperatures documented. -There were no water temperatures documented from August 2020 to June 2021. -The water temperatures documented were from 04/01/17 to 07/02/20 and ranged from 102 degrees (Fahrenheit) F to 114 degrees F. Observation of the water temperatures in the hallway resident bathroom on 06/16/21 at 8:06am revealed the water temperature at the sink fixture was 129.4 degrees F with steam emitting from the fixture and the shower fixture was 124.7 degrees F. Observation of the water temperatures in the "pink" resident bathroom on 06/16/21 at 8:10am revealed the water temperature at the sink fixture was 128.7 degrees F. Observation of the water temperatures in the hallway resident bathroom with the Administrator on 06/16/21 at 12:40 pm revealed the water temperature at the sink fixture was 125.7 degrees F and the shower fixture was 121.1 degrees F. Observation of the laundry room area on 06/16/21 at 12:43pm revealed: -There was a gray device with a large blue label resting on top of the facility's water heater located in the laundry area.	C 105		

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C 105	Continued From page 4 -The device had three knobs one for temperature control, operating mode and push to start knob. -The Administrator picked up the device and used the knob for temperature control to adjust the water heater temperature. Interview with the Administrator on 06/16/21 at 9:44am revealed staff were supposed to check the water temperatures monthly and document them on a water temperature log. Observation of the facility on 06/16/21 at 10:00am revealed there was a no water thermometer available to test the water temperatures. Interview with a resident on 06/16/21 at 8:06am revealed: -He noticed the water was too hot, but he had not noticed steam coming from the fixtures. -He used the hallway bathroom as did the other residents to shower. -The pink bathroom was used by residents for toileting and staff used the bathtub/shower in that bathroom for bathing. -He bathed himself and adjusted the water temperature for himself. -He had not told anyone about the water temperature being too hot. Interview with another resident on 06/16/21 at 8:15am revealed: -He used both bathrooms in the facility. -He noticed the water was always too hot and was steaming, but he added cold water to decrease the temperature of the water. Telephone interview with a Supervisor-in-Charge on 06/16/21 at 1:38pm revealed: -She worked at the facility since November 2020. -She checked the water temperatures monthly	C 105		

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C 105	Continued From page 5 using the fixtures in the hallway bathroom. -She used a water thermometer stored in the staff room. -She assisted two residents with their personal care and bathing. -When she assisted with their showers, she used the hallway bathroom. -She knew the water temperature range for the facility needed to be between 120 degrees F and 140 degrees F. -She tested the water temperatures monthly, but she did not document the water temperatures. -She did not document the water temperatures because she was not told to document the water temperatures. -She was instructed to notify the Administrator if the water temperature was too low or too hot. -She had only notified the Administrator once when the water temperature was too low in the winter of 2020. -She had not notified the Administrator during 2021 for any water temperature concerns. Telephone interview with the Administrator on 06/16/21 at 2:43pm revealed: -Water temperatures were tested monthly. -The water temperatures were documented on the water temperature log like the logs stored on the refrigerator. -She could not locate any other water temperature logs and the SIC told her she was not documenting the water temperatures today, on 06/16/21. -She had the digital thermometer used for water temperature testing but took it out of the facility because the batteries were dead. -There was a manual thermometer in the facility. -She was not aware that the water temperatures were higher than 116 degrees F and was surprised when the water temperature tested	C 105		

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C 105	Continued From page 6 above 120 degrees F. -She had told staff to notify her if the water temperature was below 100 degrees F or higher than 116 degrees F because she could instruct them on what to do to adjust the water temperature using the device on the top of the water heater. -She held staff responsible for ensuring the facility water temperatures remained between the range of 100 degrees F and 116 degrees F. Observation of the water temperatures in the hallway resident bathroom on 06/16/21 at 3:21pm revealed the water temperature at the sink fixture was 122.4 degrees F. Observation of the water temperatures in the "pink" resident bathroom on 06/16/21 at 3:19pm revealed the water temperature at the sink fixture was 122.4 degrees F.	C 105		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.	C 202		

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C 202	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#3) had completed two-step tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL-2 dated 04/06/21 revealed: -Diagnoses included schizophrenia undifferentiated type, and history of COVID-19. -There was an admission date of 04/13/20 documented for Resident #3. Review of Resident #3's tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test given on 04/07/20 and read negative on 04/09/20. -There was no documentation of a second TB skin test. Interview with Resident #3 on 06/16/21 at pm revealed: -He had a TB skin test completed prior to his admission to the facility in 2020. -He thought the TB skin test was negative. -He did not have a chest x-ray for TB. -He did not have another TB skin test since his admission. Telephone interview with a Supervisor in Charge (SIC) on 06/16/21 at 1:39pm revealed: -She could not say that she saw Resident #3's second TB skin test during her record review. -She was unsure if he had a second TB skin test and the Administrator arranged the second TB test for residents.	C 202	Resident #3 will have his second step TB completed by July 31st. The administrator will ensure that all TB steps for all new residents will be completed within a reasonable amount of time.	

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C 202	Continued From page 8 Telephone interview with the Administrator on 06/16/21 at 2:38pm revealed: -She preferred the place residents came from completed the TB skin testing prior to admission. -Once the resident was admitted to the facility, she arranged a second TB test as soon as possible. -Resident #3 had a TB skin test upon admission. -Due to the pandemic, she did not arrange a second TB test for him. -Residents were seen by their primary care provider via telehealth during the pandemic so they were unavailable to provide the second TB test to Resident #3. -She was responsible for ensuring residents had a completed TB skin test upon admission to the facility.	C 202	The administrator will ensure that all new residents will have all admission paper works completed in a timely manner. The residents involved will have their paper work completed by July 31, 2021.	
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on record reviews and interviews, the	C 212		

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C 212	Continued From page 9 facility failed to ensure the Resident Register was completed within 72 hours of admission for 2 of 3 sampled residents (#2 and #3). The findings are: 1. Review of Resident #2's current FL-2 dated 09/22/20 revealed diagnoses included bipolar with psychotic features and psychosis. Based on record reviews and interviews, there was no Resident Register available for review for Resident #2. Interview with Resident #2 on 06/16/21 at 8:40am revealed he had a guardian and had lived at the facility since the latter part of September 2020. Telephone interview with the Administrator on 06/16/21 at 2:28pm revealed: -A former staff was at the facility in August 2020 and completed the admission paperwork for Resident #2. -She recalled the former staff stating she was supposed to meet with Resident #2's guardian to sign his Resident Register. -She did not know where the former staff placed Resident #2's Resident Register. Refer to the telephone interview with the Administrator on 06/16/21 at 2:28pm. 2. Review of Resident #3's current FL-2 dated 04/06/21 revealed diagnoses included schizophrenia undifferentiated type, and history of COVID-19. Review of Resident #3's record revealed there was no resident register.	C 212		

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C 212	Continued From page 10 Interview with Resident #3 on 06/16/21 at 7:48am revealed: -He resided at the facility since May 2020. -He had a guardian. Telephone interview with the Administrator on 06/16/21 at 2:28pm revealed she did not know Resident #3's Resident Register was not in his record. Refer to the telephone interview with the Administrator on 06/16/21 at 2:28pm. Telephone interview with the Administrator on 06/16/21 at 2:28pm revealed: -She knew she was supposed to complete a new resident's register within 72 hours of admission. -She thought a staff had completed a records review in April 2021 to ensure the Resident Registers were completed and in the resident records. -She had not checked the resident records after April 2021 and this was her oversight. -She should have checked the resident records to ensure the Resident Registers were completed and in the records. -She was responsible for ensuring the resident register was completed within 72 hours of admission.	C 212		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or	C 249		

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C 249	Continued From page 11 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure blood pressure (BP) checks were implemented and documented as ordered for 2 of 3 sampled residents with orders for monthly BP checks (Resident #1 and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 06/10/21 revealed: -Diagnoses included chronic obstructive pulmonary disease, spondylosis of cervical spine, schizophrenia, hypertension, and constipation. -There was an order for monthly blood pressure (BP) monitoring. Review of Resident #1's previous FL-2 dated 06/10/20 revealed there was an order for monthly BP monitoring. Review of Resident #1's April 2021 medication administration record (MAR) revealed: -There was no entry for BP monitoring. -There were no BP readings documented on the back of the MAR. Review of Resident #1's May 2021 MAR revealed: -There was no entry for BP monitoring. -There were no BP readings documented on the back of the MAR. Review of Resident #1's June 2021 MAR revealed:	C 249	The administrator will ensure that the staff will take and record all vital signs as per doctor's order. The administrator will do a routine weekly check to make sure orders are carried out correctly. Correction date- 07/31/21- SS- 8/2/21	

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C 249	Continued From page 12 -There was no entry for BP monitoring. -There were no BP readings documented on the back of the MAR. Review of Resident #1's BP log revealed: -There were columns for the date, time, BP and notes. -There were BPs documented monthly from June 2019 to January 2021 and the BPs ranged from 100/40 to 128/85. -There were BPs documented twice monthly for April 2019 and May 2019 ranging from 105/68 to 108/82. Interview with Resident #1 on 06/16/21 at 12:35pm revealed he had his BP monitored by his PCP when she came to the facility. Attempted telephone interview with Resident #1's PCP's office on 06/16/21 at 2:13pm. Refer to the interview with the Administrator on 06/16/21 at 12:37pm. Refer to the telephone interview with the SIC on 06/16/21 at 1:38pm. Refer to the telephone interview with the Administrator on 06/16/21 at 2:38pm. 2. Review of Resident #3's current FL-2 dated 04/06/21 revealed diagnoses included schizophrenia undifferentiated type, and history of COVID-19. Review of Resident #3's April 2021 medication administration record (MAR) revealed: -There was no entry for BP monitoring. -There were no BP readings documented on the back of the MAR.	C 249		

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C 249	Continued From page 13 Review of Resident #3's May 2021 MAR revealed: -There was no entry for BP monitoring. -There were no BP readings documented on the back of the MAR. Review of Resident #3's June 2021 MAR revealed: -There was no entry for BP monitoring. -There were no BP readings documented on the back of the MAR. Review of Resident #3's BP log revealed: -There were columns for the date, time, BP and notes. -There were BPs documented monthly from April 2020 to November 2020 and the BPs ranged from 130/70 to 140/85. Interview with Resident #3 on 06/16/21 at 11:25am revealed he had his BP checked weekly and the last time it was checked was last week. Attempted telephone interview with Resident #1's PCP's office on 06/16/21 at 2:13pm. Refer to the interview with the Administrator on 06/16/21 at 12:37pm. Refer to the telephone interview with the SIC on 06/16/21 at 1:38pm. Refer to the telephone interview with the Administrator on 06/16/21 at 2:38pm. Interview with the Administrator on 06/16/21 at 12:37pm revealed: -She telephoned a SIC who worked in the facility frequently to ask the location of the residents	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035029	A. BUILDING: _____ B. WING _____	R 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 249	Continued From page 14 BPs. -She was told that the SIC documented residents' BPs on the MARs or the BP log. -She was not able to locate the residents current monthly BP readings. Telephone interview with a SIC on 06/16/21 at 1:38pm revealed: -She took the residents' BPs based on what was ordered by the PCP. -Most of the residents had an order for monthly BP monitoring. -She had obtained monthly BPs for residents and documented the BPs on the MARs. -She had documented BPs on the BP logs when she saw other staff documenting BPs on the BP logs. -She was not always staff at the facility and maybe another staff took the residents monthly BP. -She did not know why the BPs could not be located because she knew she did the April 2021 BPs. Telephone interview with the Administrator on 06/16/21 at 2:28pm revealed: -She expected staff to obtain BP's as ordered by the PCP. -She knew residents had BP's ordered monthly. -She had not reviewed residents' BPs, but she asked the residents and they told her that their BPs were checked. -She was responsible for ensuring residents' blood pressures were checked as ordered and documented.	C 249		