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	HAL066011	A. BUILDING: _____ B. WING _____	R 07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

(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
D 000	Initial Comments The Adult Care Licensure Section and the Northampton County Department of Social Services conducted an annual survey, a follow up survey and complaint investigation from July 11, 2022 to July 12, 2022. The complaint investigation was initiated by the Northampton County Department of Social Services on June 22, 2022.	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 ensure resident rooms were kept clean and in good repair, to include debris under furniture, a spider and spider web in a resident's bathroom, and a dead bug beside a dresser, and stains on the walls and floor in resident rooms, bathrooms and common areas. The findings are: Observation of N.C. Department of Health and Human Services Community Inspection report dated 05/07/21 revealed: -The facility was deducted 1 point for not having floors clean, carpet clean, dry and odor free.	D 074		

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-The facility was deducted 1 point for not having walls and ceilings cleanable, clean and in good repair.
-The facility was deducted 1 point for not having the premises clean with no breeding places or rodent harborage.
-The facility was deducted 0.5 point for not having patient contact items in good repair, properly stored, cleaned and disinfected.
-It was noted that there was debris on the floor in several resident rooms.
-It was noted that multiple rooms had wall damage from headboards of beds and holes in the walls from unknown sources.

1. Observation of Resident Room #10 on 06/22/22 at 9:22am revealed:
-There was one resident that occupied this room.
-The resident was laying in bed.
-There was dirt, dust, food and a used cloth mask under her bed.
-There was a duffle bag in the floor of the closet open with clothes and slippers hanging out of it.
-There were caked up brown substances in the corners of the closet and down the sides of the closet floor by the baseboard.
-There was an unidentifiable green plastic debris in the corner of the closet on the floor.
-The 2nd closet in Resident Room #10 was not occupied.
-There were caked up brown substances in the corners of the 2nd closet and down the sides of the closet floor by the baseboard.
-There were pieces of napkin paper on the floor of the 2nd closet.
-There were brownish stains on the floor alongside the baseboards of the room.

Observation of resident bathroom in Resident Room #10 on 06/22/22 at 9:22am revealed:

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-The bathroom had brownish stains on the floor along the wall of the room.
-There was debris and brownish stains and black specks behind the commode on the floor and against the wall.
-There was a spider web and a long legged spider crawling within the web attached to the bottom of the right side of the commode.

Interview with a family member of Resident that resided in Room #10 on 06/21/22 at 12:55pm revealed:
-The family member had visited the facility on 6/10/22 and 06/12/22.
-The bathroom for Resident Room #10 was not clean.
-There was a cobweb found with a spider in it at the right side of the commode closest to the wall.
-There was a lot of trash and dust under the resident's bed.
-There was a red substance on the floor, and it was reported to the facility staff.
-When the family member returned to the facility on 06/12/22 all the areas of concern were still not corrected.
-The family member reported concerns to facility staff on the day of the visit 06/10/22.
-The facility was not cleaning the residents' rooms.

Review of housekeeping's deep cleaning schedule for June 2022 revealed:
-Resident Room #10 was to be deep cleaned on 06/08/22 and 06/29/22.
-The Special Care Unit (SCU) Coordinator initialed both 06/08/22 and 06/29/22, which indicated rooms were deep cleaned.

Review of pest control logs for the facility revealed:

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D 074	Continued From page 3 -On service date 05/30/22 ants were spotted in 5 resident rooms. -This was the only service date indicated for 2022. Refer to interview with a Personal Care Aide (PCA) on 07/12/22 at 3:10pm. Refer to interview with a PCA on 06/22/22 at 11:55am. Refer to interview with Housekeeping Staff on 06/22/22 at 11:26am. Refer to interview with Lead Housekeeper on 07/12/22 at 3:26pm. Refer to interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm. Refer to interview with the Executive Director (ED) on 07/12/22 at 6:08pm. 2. Observation of Resident Room #12 on 06/22/22 at 10:40am revealed: -Two residents occupied Resident room #12. -Under bed #1 there was an empty plastic cup on the floor. -There were shoes under the bed with another residents' name written in marker on them. The named resident on the shoe did not reside in Resident Room #12. -There was dust particles and food crumb debris under the bed. -Under bed #2 there were articles of clothing bawled up under the bed. -There was a jacket on the bed that had two flies on it. -There were dust particles, food crumb debris and an ink pen under the bed.	D 074		

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D 074	Continued From page 4 -There were brownish stained marks on the floor behind the bed. -There was one dresser in the room and there were brownish stained marks alongside the walls beside the dresser. -There was a dead bug lying on its back on the left side of the dresser on the floor. -There was a sticky red substance on the floor behind the dresser. -The air conditioning cord was plugged in and was laying stuck to the substance. -There was caked up substances along the walls of the room that appeared to be dust and dirt build up. -Closet #2 closest to the window was missing its door. -There was a brown to black substance caked on the floor at the corners wrapping around the doorframe to the closet. Refer to interview with a Personal Care Aide (PCA) on 07/12/22 at 3:10pm. Refer to interview with a PCA on 06/22/22 at 11:55am. Refer to interview with Housekeeping Staff on 06/22/22 at 11:26am. Refer to interview with Lead Housekeeper on 07/12/22 at 3:26pm. Refer to interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm. Refer to interview with the Executive Director (ED) on 07/12/22 at 6:08pm. 3. Observation of Resident bathroom #12 on 06/22/22 at 9:34am revealed:	D 074		

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-There were multiple residents that shared the bathroom for Resident Room #12.
-There was a dark red substance droplet on the floor beside the commode.
-There was a dark red substance droplet on the toilet seat.
-There was a red tint to the toilet bowl water in the commode.
-There was a brown dried up stain running down the side of the commode base.
-There were brownish yellow stains at the bottom of the base of the commode on both sides, where the screws of the toilet were found.
-There were splatter stains against the wall at the back of the commode towards the bottom.

Interview with a Resident that resided in Room #12 at 10:40am revealed:
-The red substance on the floor, seat of commode and inside the commode was blood.
-The blood came from him as he had just used the bathroom.
-He was not able to provide specifics regarding housekeeping habits for his room.

Interview with the Special Care Unit (SCU) Coordinator on 06/22/22 at 10:44am revealed:
-She was not aware of the blood droplets found on the floor of the bathroom, commode seat and in the bowl of the toilet.
-The SCU Coordinator returned to sitting on the front porch with a resident.

Interview with Lead Supervisor on 06/22/22 at 12:40pm revealed:
-She was not aware of the blood droplets in Resident Room #12's bathroom.
-She was not aware that staff had already been notified of the issue.
-She was not aware the issue was unresolved.

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D 074	Continued From page 6 -She stated she would take care of it now. Review of Housekeeping's deep cleaning schedule for June 2022 revealed: -Resident Room #12 was to be deep cleaned on 06/09/22 and 06/23/22. -The Executive Director (ED) initialed for 06/09/22 to indicate the room was deep cleaned. -The SCU Coordinator initialed for 06/23/22 to indicate the room was deep cleaned. Refer to interview with a Personal Care Aide (PCA) on 07/12/22 at 3:10pm. Refer to interview with a PCA on 06/22/22 at 11:55am. Refer to interview with Housekeeping Staff on 06/22/22 at 11:26am. Refer to interview with Lead Housekeeper on 07/12/22 at 3:26pm. Refer to interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm. Refer to Interview with the Executive Director (ED) on 07/12/22 at 6:08pm. 4. Observation of the hallway closest to the living room common area on 06/22/22 at 9:40am revealed: -There was a caked up brown substance lining the corner of the door closest to the laundry room. -There was dust and debris on the baseboard area closest to the laundry room door. -The paint was chipped at the entryway doors closest to the laundry room. -The doors closest to the nurses' station were	D 074		

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propped open.
-Behind the left door was a caked up brownish yellow substance in the corner of the doorframe.
-There were unidentified brown shavings sitting on the baseboard closest to the close of the door.
-Behind the right door, there was a cobweb with bugs inside of it and a brownish yellow caked up substance on the floor.
-There was a footprint, several dried up spill mark stains, and streaks on the floor in hallways.

Review of Housekeeping's deep cleaning schedule for June 2022 revealed the hallways were not indicated on the deep cleaning schedule.

Refer to Interview with a Personal Care Aide (PCA) on 07/12/22 at 3:10pm.

Refer to Interview with a PCA on 06/22/22 at 11:55am.

Refer to Interview with Housekeeping Staff on 06/22/22 at 11:26am.

Refer to Interview with Lead Housekeeper on 07/12/22 at 3:26pm.

Refer to Interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm.

Refer to Interview with the Executive Director (ED) on 07/12/22 at 6:08pm.

5. Observation of Resident Room #2 on 06/22/22 at 10:09am revealed:
-He occupied this room alone.
-There was a scratch against the wall around 8-12 inches long that ran horizontally and the paint from the wall was chipped.

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-At the top left corner of his closet floor, there was brown substance built up.
-There was a dark substance on the floor in between the two closest running down the base board at the bottom.
-The floor behind the bedroom door had a black substance caked up in the corner of the baseboard and running down the wall.
-The baseboards had a brown substance on them by the bathroom exterior side of the door.

Interview with the Resident that resided in room #2 on 06/22/22 at 10:14am revealed he was no sure how often cleaning took place.

Review of Housekeeping's deep cleaning schedule for June 2022 revealed:
-Room #2 was to be deep cleaned on 06/06/22 and 06/30/22.
-The Special Care Unit (SCU) Coordinator initialed both 06/68/22 and 06/30/22, which indicated the rooms were deep cleaned.

Refer to Interview with a Personal Care Aide (PCA) on 07/12/22 at 3:10pm.

Refer to Interview with a PCA on 06/22/22 at 11:55am.

Refer to Interview with Housekeeping Staff on 06/22/22 at 11:26am.

Refer to Interview with Lead Housekeeper on 07/12/22 at 3:26pm.

Refer to Interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm.

Refer to Interview with the Executive Director (ED) on 07/12/22 at 6:08pm.

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D 074	Continued From page 9 6. Observation of Resident Room #14 on 06/22/22 at 9:30am revealed: -There was debris under the residents' bed. -There was a hole in the wall in the wall closest to the exit door. -There were several markings on the floor that were gray in color and covered multiple square tiles of floor. -There was a brown mark in the center of the floor that resembled an uncleaned spill or food mark. -The closest had clack marks on the wall that resembled mold. -The floor of the closet was yellowish orange in color, there were clothes and a pack of incontinent supplies on the floor. -There was excess brown buildup caked in the entrance corner of the closet running alongside the walls of the closet floor. -There were small plastic unidentified pieces in the floor of his closet. Review of Housekeeping's deep cleaning schedule for June 2022 revealed: -Resident Room #14 was to be deep cleaned on 06/10/22 and 06/24/22. -The Special Care Unit (SCU) Coordinator initialed both 06/10/22 and 06/24/22, which indicated rooms were deep cleaned. Refer to Interview with a Personal Care Aide (PCA) on 07/12/22 at 3:10pm. Refer to Interview with a PCA on 06/22/22 at 11:55am. Refer to Interview with Housekeeping Staff on 06/22/22 at 11:26am.	D 074		

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D 074	Continued From page 10 Refer to Interview with Lead Housekeeper on 07/12/22 at 3:26pm. Refer to Interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm. Refer to Interview with the Executive Director on 07/12/22 at 6:08pm. 7. Observation of Resident Room #7 on 06/22/22 at 9:45am revealed: -The resident was the only occupant of the room. -He shared a bathroom with a resident in an adjourning room. -Behind the commode, there was black specks of unidentified stains on the floor. -There was a brownish colored stain around the base of the bowl of the toilet and the floor connecting to the commode. -The exit door of the bathroom frame at the bottom on the floor contained black build up substance. -The paint on the walls of the bathroom doorframe was chipped. -There was a brownish stain on the floor in front of the closet used by the resident. -There was plastic trash and a metal object with a screw going threw it on the floor in front of the closet. -The baseboard and the flooring under the sink had a black stain running across the width of the sink. -The exit door for the room on the inside of the room, contained black and brown build up at the bottom of the doorframe. Interview with Resident of Room #7 on 06/22/22 at 9:59am revealed he was not certain how often the facility was cleaned.	D 074		

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Review of Housekeeping's deep cleaning schedule for June 2022 revealed:
-Resident Room #7's room was to be deep cleaned on 06/02/22 and 06/28/22.
-The Special Care Unit (SCU) Coordinator initialed both 06/02/22 and 06/28/22, which indicated rooms were deep cleaned.

Refer to Interview with a Personal Care Aide (PCA) on 07/12/22 at 3:10pm.

Refer to Interview with a PCA on 06/22/22 at 11:55am.

Refer to Interview with Housekeeping Staff on 06/22/22 at 11:26am.

Refer to Interview with Lead Housekeeper on 07/12/22 at 3:26pm.

Refer to Interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm.

Refer to Interview with the Executive Director (ED) on 07/12/22 at 6:08pm.

Interview with Housekeeping Staff on 06/22/22 at 11:26am revealed:
-She had worked for the facility as a housekeeper since March 2022.
-She only worked 3 days each week.
-Every day she worked, she would wipe down the lobby doors, furniture, swept and mopped all of the halls when no one was walking on the floors.
-She emptied the residents' trash in their rooms, cleaned the commode, wiped down the sink, furniture, mirror, swept and mopped the floors in the residents' room.
-She did not clean the walls of the facility or the

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walls of resident rooms.
-She only moved furniture within a resident's room to see if there was trash underneath it.
-She did not clean the residents' closets.
-She had swept all of the floors and was going to mop after her lunch break.
-She had finished cleaning all of the resident's rooms.
-When she returned from her lunch break, she would go back over everything again.

Interview with a Personal Care Aide (PCA) on 06/22/22 at 11:55am revealed:
-There were 3 housekeepers for this building, and it was their responsibility to keep the facility clean.
-The PCA would assist in making sure the resident's room and closet were straightened up.

Interview with a second PCA on 07/12/22 at 3:10pm revealed:
-The housekeeping staff were supervised by the lead housekeeper.
-They cleaned residents' rooms in the morning and then again around 2:30pm.
-They would make sure there was no trash on the floors, clean the bathroom and changed the trash bag.
-She was not aware if the housekeeping staff moved furniture when cleaning.

Interview with Lead Housekeeper on 07/12/22 at 3:26pm revealed:
-There were 3 housekeepers assigned to maintain the cleanliness of the building and they reported to the facility at 7:00 am daily.
-They were expected to deep clean 2 rooms per day.
-A deep cleaning included pulling everything out of the room and placing it in the hallway. They would start wiping down the window seal, window,

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blinds, furniture and curtains. They would clean the bathroom and the entire resident room from top to bottom to include sweeping and moping the room and bathroom. They were expected to dust and pick up and clean the residents' closets.
-He was cleaning the base of the commode and the walls and floors when he worked in the building.
-He only worked in the building as a housekeeper every other weekend.
-Housekeeping staff were expected to clean behind the commode at the base and walls.
-He did not feel the task was not getting done and the housekeeping staff would not listen to him.
-He would report his concerns to the Executive Director (ED), and the problem would be corrected for a little while.
-Daily cleaning of the facility was similar to deep cleaning without moving the furniture out of the room.
-The housekeeping staff were expected to check under beds, behind chairs and dressers in routine cleaning.
-There should not be dust and dirt found in any resident's room.
-The housekeeping staff was not checking out with him before they leave for the day.

Interview with Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm revealed:
-The Lead Housekeeper (LH) was the supervisor for housekeeping staff.
-The LH would check to make sure housekeeping duties were completed daily.
-Housekeeping staff would deep clean 2 to 3 resident rooms each week.
-There was a monthly calendar that indicated what should be deep cleaned.
-When deep cleaning was finished the calendar was to be marked completed.

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D 074	Continued From page 14	D 074		

-There would be a sign on the door indicating which room was being deep cleaned.
-A deep cleaning would include removal of resident curtains and privacy curtain taken down and cleaned. Housekeeping staff would strip and sanitize the bed and clean everything in the room.
-The SCU Coordinator had observed these tasks being done daily.
-The SCU Coordinator believed the housekeeping staff could do a better job.
-When not deep cleaning the housekeeping staff was expected to maintain daily cleaning practices.
-The SCU Coordinator had not seen any spiders inside the facility and the facility had routine pest maintenance coming into the building.

Interview with the Executive Director (ED) on 07/12/22 at 6:08pm revealed:
-All facility staff would help daily with housekeeping needs.
-The LH was the housekeeping supervisor and there were specific staff members assigned to complete housekeeping duties daily.
-She expected the housekeeping staff to clean the facility just as if it was their own home.
-It was the housekeeper's responsibility to refill paper towel and toilet paper dispensers.
The housekeepers were to deep clean daily. This would include moving the furniture within a resident rooms and cleaning all areas of that room.
-The housekeeping staff would go by the deep cleaning calendar to know which rooms were expected to be deep cleaned daily.
-The staff could deep clean more often if the need arises.
-Routine cleaning was being performed daily, which included sweeping, moping, emptying the trash, dust, bathrooms and cleaning the window

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D 074	Continued From page 15 seals. -The management team would observe task being completed throughout the shift. -She was not aware if the housekeeping staff was being checked out prior to the end of their shift.	D 074		
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 ensure the resident restrooms and community bathrooms were free from hazards to include a broken towel rack with sharp edges and a sharp rectangular piece of metal at the bottom of a community bathroom restroom stall door. The findings are: 1. Observation of a private bathroom in redisdent Room #1 on 07/11/22 at 9:30am revealed -The towel rack below the paper towel holder to the left of the sink was missing; there was one section of towel holder to the left that had two sharp edges approximately 1 ½ inches vertically under the light switch. Interview with a housekeeper on 07/11/22 at 2:15pm revealed:	D 079		

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-He cleaned resident bathrooms every morning and ensured there were no hazards.
-He was not aware that the towel rack was missing in Room #1 and that there was one section of towel holder to the left that had two sharp edges approximately 1 ½ inches vertically under the light switch.
-He was shocked that he had not noticed the sharp edges and was concerned that a resident could have cut themselves on the broken towel rack.

Interview with the lead housekeeper on 07/11/22 at 3:15pm revealed:
-He had not noticed the broken towel rack in resident Room #1.
-He should have noticed the danger of the sharp edges on the broken towel rack.
-The personal care aides (PCAs) or medication aides (MAs) would usually notify him if something needed to be repaired in the facility.
-He was responsible for ensuring there were not any hazards related to maintenance and housekeeping in the building.

Interview with the Executive Director (ED) on 07/12/22 at 5:45pm revealed:
-She was not aware that there was a broken towel rack in the bathroom of resident Room #1.
-The lead housekeeper attended morning meetings and was made aware of any needed repairs at the facility as they occurred.
-The facility had received part time assistance from a maintenance team member from another facility for the past 4 months.
-She was concerned that the sharp edges on the broken towel rack could have injured a resident.

2. Observation of the community bathroom on 07/11/22 at 9:42am revealed:

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D 079	Continued From page 17 -There was a sharp rectangular metal piece, approximately 2 inches that hung down restroom toilet stall from the bottom of the door when opened. -The sharp rectangular metal piece was on bottom of the right side of the door when the door was opened. Interview with the lead housekeeper on 07/11/22 at 3:15pm revealed: -He was not aware that there was a rectangular piece of metal hanging down from the bathroom stall door in the community bathroom. -He was responsible for ensuring there were not any hazards related to maintenance and housekeeping in the building. Interview with the Executive Director (ED) on 07/12/22 at 5:45pm revealed: -She was not aware that there was a sharp piece of metal hanging down from the bathroom stall door in the community bathroom. -The metal piece could have cut a resident's leg. -The facility had received part time assistance from a maintenance team member from another facility for the past 4 months.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult 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 ensure the toilet in a resident room was	D 105		

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D 105	Continued From page 18 maintained in a safe and operating condition. The findings are: Observation of Resident #1's bathroom in his room on 07/12/22 at 2:59pm revealed the toilet seat was missing from the commode. Interview with Resident #1 on 07/12/22 at 3:00pm revealed: -He reported the missing toilet seat to housekeeping staff about 2 days ago. -He had not spoken to any other staff about the toilet seat. -The seat had been missing for at least a week. -A resident who had lived in the room next door had broken the toilet seat. -The toilet seat had been removed by staff. -Using the toilet had been difficult with the seat missing. Interview with the Lead Housekeeper on 07/12/22 at 3:11pm revealed: -Resident #1 had reported the toilet seat was missing on 07/11/22. -He was not aware of the toilet seat being missing prior to 07/11/22. -He looked for an extra toilet seat but one was not available. -He did not report the missing toilet seat to the Executive Director (ED). Interview with the Maintenance Director on 07/12/22 at 3:08pm revealed: -He was not made aware of the toilet seat being missing from Resident #1's room. -He had asked the Lead Housekeeper to replace the missing toilet seat. -Housekeeping was expected to report maintenance issues.	D 105		

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D 105	Continued From page 19 Interview with the Special Care Unit (SCU) Coordinator on 07/12/22 at 5:09pm revealed: -All residents bathrooms were cleaned daily by housekeeping. -No one had reported the toilet seat missing from Resident #1's bathroom. -Maintenance could have purchased a new toilet seat. -She had concerns of a resident using a commode without a toilet seat. Interview with the ED on 07/12/22 at 5:45pm revealed: -Housekeeping staff were to clean the residents' rooms daily and report all maintenance issues. -Resident #1's missing toilet seat had not been reported to her. -She did not see a missing toilet seat as a hazard because residents had access to the community bathrooms. -She expected maintenance to repair or replace broken or missing fixtures.	D 105		
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.	D 113		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure that hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 5 fixtures in the residents' common bathroom (1st and 2nd showers), residents' rooms (#9, #14, and #16) of 85.6° degrees F to 98° degrees F.

The findings are:

Observation of resident room #9 bathroom on 07/11/22 at 9:32am revealed the hot water temperature at the sink was 85.6°F.

Observation of resident room #16 bathroom on 07/11/22 at 9:39am revealed the hot water temperature at the sink was 90.2°F.

Observation of resident room #14 bathroom on 07/11/22 at 9:54am revealed the hot water temperature at the sink was 89.0°F.

Interview with a resident on 07/11/22 at 9:41am revealed:
-The hot was "about medium" and was okay.
-The hot water was not hot.
-She had not complained to staff about the hot water temperature.

Observation of residents' common bathroom on 07/11/22 at 10:00am revealed:
-The hot water temperature at the 2nd shower was 98.0°F.
-The hot water temperature at the 3rd shower was 96.0°F.

Review of the hot water temperature log dated 05/20/22 revealed:
-The hot water temperature in room 9 at the sink

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was 102.0°F.
-The hot water temperature in room 14 at the sink was 104.0°F.
-There was no documentation for the residents' common bathroom.

Review of the hot water temperature log dated 07/07/22 revealed hot water temperature was not documented for residents' rooms 9, 14 and 16 and not for the fixtures in the residents' common bathroom.

Interview with the Lead Housekeeper on 07/11/22 at 8:09am revealed:
-He completed random hot water temperature checks 1 to 2 times weekly.
-The hot water temperature was completed about one week ago and it was at 113.0°F in the rooms (did not specify which resident rooms).
-He had not completed hot water temperatures for the shower fixtures in the residents' common bathroom.
-He had adjusted the hot water temperature when it was out of range.
-The required hot water temperature range was 114.0°F to 121.0°F.
-There were two hot water heaters, one for each side of the building.

Observation of water thermometers being calibrated on 07/12/22 at 10:43am revealed:
-The Lead Housekeeper and Surveyor's water thermometers were placed in a cup of ice water.
-The Lead Housekeeper thermometer temperature was 32.0°F.
-The Surveyor's thermometer temperature was 32.8°F.

Observations of re-check of water temperatures with the Lead Housekeeper in the residents'

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common bathroom on 07/12/22 revealed:
-At 10:52am the hot water temperature at the 2nd shower was 98.6°F.
-At 10:53am the hot water temperature at the 2nd shower was 97.2°F.

Observations of re-check of water temperatures with the Lead Housekeeper in resident room 9 on 07/12/22 at 11:02am revealed the hot water temperature at the sink was 80.0°F.

Observations of re-check of water temperatures with the Lead Housekeeper in the residents' common bathroom on 07/12/22 revealed:
-At 4:33pm the hot water temperature at the 2nd shower was 109.0°F.
-At 4:34pm the hot water temperature at the 3rd shower was 104.0°F.

Observations of re-check of water temperatures with the Lead Housekeeper in resident room 16 on 07/12/22 at 4:37pm revealed the hot water temperature at the sink was 83.0°F.

Observations of re-check of water temperatures with the Lead Housekeeper in resident room 14 on 07/12/22 at 4:39pm revealed the hot water temperature at the sink was 96.0°F.

Observations of re-check of water temperatures with the Lead Housekeeper in resident room 5 on 07/12/22 at 4:44pm revealed the hot water temperature at the sink was 114.0°F.

Interview with the Maintenance Supervisor on 07/12/22 at 3:08pm revealed:
-He checked both hot water heaters valves earlier.
-The mixture valve for both hot water heaters would need to be repaired or replaced.

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D 113	Continued From page 23 -He ordered a new mixture valve to replace the old mixture value if it could not be replaced. -The Lead Housekeeper had adjusted both hot water heaters. Interview with the Special Care Unit (SCU) Coordinator on 07/12/22 at 5:09pm revealed: -The Personal Care Aides (PCA) and housekeeping staff had completed hot water checks before hiring maintenance staff. -Hot water temperature checks were completed randomly and once a week. -Residents had not complained about the hot water being cool. -The maintenance staff were responsible for completing hot water checks. Interview with the Executive Director on 07/12/22 at 5:54pm revealed: -Residents had not complained to her about the water temperature being cold or cool. -The Lead Housekeeper and maintenance staff completed hot water temperature checks. -Hot water temperatures were checked weekly. -The maintenance staff was responsible for ensuring hot water temperatures were completed weekly and documenting the temperatures.	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to provide personal care according to the care plan and assessed needs for 1 of 3 residents sampled (#2) related to nail care and grooming.

The findings are:

Review of Resident #2's current FL-2 dated 01/17/22 revealed:
-He had a diagnosis of stroke with left sided hemiparesis, multi-infarct dementia, history of falls, hyperkalemia, insomnia, depression and was a diabetic.
-He was admitted to the special care unit facility on 06/24/21 and was intermittently disoriented.
-He required personal care assistance with bathing.

Review of Resident #2's care plan dated 02/09/22 revealed:
-The resident was ambulatory with a wheelchair.
-He had limited strength in his upper extremities, which included his left side, leg and arm from past stroke.
-He required limited assistance with transfers.
-He required extensive assistance with grooming and personal hygiene.

Observation of Resident #2 on 06/22/22 at 9:41am revealed:
-The resident was sitting in his wheelchair.
-His pointer fingernail on his right hand was 0.5 inches past the tip of his finger. It had a jagged sharp nail with a brown substance underneath it.
-His thumb, middle and pinky fingernail on his right hand was 0.5 inches past the tip of his finger

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and had a brown substance underneath it.
-His ring fingernail on his right hand was 0.75 inches past the tip of his finger and had a brown substance underneath it.
-His left hand was contracting into the palm of his hand.
-The second fingernail from the pinky on his left hand was 1.5 inches past the tip of his finger and pressing against the pam of his hand.
-The hair on his head was bushy and overgrown.
-The top if his mustache hair was starting to grow onto his lip.
-The hair on his face was thick.

Interview with Resident #2 on 06/22/22 at 9:59am revealed:
-The facility staff was not cleaning or trimming his nails.
-He was aware his nails were long and dirty.
-His face was not shaved regularly and his hair was too long.
-He did not like his hair to be long.
-He had not reported concerns with facility staff.
-He was not sure when his fingernails were cleaned or trimmed.
-He was not sure when he last had a haircut or a shaving.

Review of Resident #2's Nail Care Point of Care History Log for June 2022 revealed:
-The task of nail care was to be completed every Tuesday and Thursday.
-His logs indicated nail care was provided every Tuesday and Thursday in June 2022.
-The logs indicated he also received nail care consecutively on 06/12/22, 06/13/22 and 06/14/22.
-No refusals of care were documented for the month of June 2022.

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Review of Resident #2's Nail Care Point of Care History Log for July 2022 revealed:
-The task of nail care was to be completed every Tuesday and Thursday.
-His logs indicated nail care was provided on 07/05/22 and 07/07/22.
-Nail care was not documented as completed or attempted for 07/12/22.
-Nail care logs were electronically printed on 07/13/22.
-No refusals of care were documented for the month of July 2022.

Review of Resident #2's Shave Point of Care History Log for June 2022 revealed:
-The task of shaving was to be completed every Tuesday and Thursday.
-His logs indicated he was shaved every Tuesday and Thursday in June 2022.
-His logs indicated he was also shaved consecutively on 06/12/22, 06/13/22 and 06/14/22.
-No refusals of care were documented for the month of June 2022.

Review of Resident #2's Shave Care Point of Care History Log for July 2022 revealed:
-The task of shaving was to be completed every Tuesday and Thursday.
-His logs indicated he was shaved on 07/05/22 and 07/07/22.
-Shave care was not documented as completed or attempted for 07/12/22.
-Shave care logs were electronically printed on 07/13/22.
-No refusals of care were documented for the month of July 2022.

Review of Resident #2's Hair Care Point of Care History Log for June 2022 revealed:

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RICH SQUARE MANOR	400 N MAIN STREET RICH SQUARE, NC 27869

(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
D 269	Continued From page 27 -The task of hair care was to be completed every Tuesday and Thursday. -His logs indicated nail care was provided every Tuesday and Thursday in June 2022. -The logs indicated he also received nail care consecutively on 06/12/22, 06/13/22 and 06/14/22. -No refusals of care were documented for the month of June 2022. Record review of Resident #2's Hair Care Point of Care History Log for July 2022 revealed: -The task of hair care was to be completed every Tuesday and Thursday. -His logs indicated nail care was provided on 07/05/22 and 07/07/22. -Hair care was not documented as completed or attempted for 07/12/22. -Hair care logs were electronically printed on 07/13/22. -No refusals of care were documented for the month of July 2022. Observation of Staff Memo Log bulletin board posted on the wall behind the nurse's desk on 06/22/22 indicated: -During the 7:00am-3:00pm shift nail care was to be completed every Tuesday as needed for each resident. -All shifts were to complete shaving task for all residents. -There were to be "no exceptions or excuses" for not completing personal care task for all residents. -Any refusals of care were to be documented and reported. Review of Resident #2's Progress Notes for June and July 2022 indicated there were no personal	D 269		

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care refusals documented.

Interview with a Personal Care Aide (PCA) on 06/22/22 at 11:55am revealed:
-There was no set day for nail care task to be completed.
-Nail care was not part of the shower process.
-Nail care would be completed after breakfast.
-She was so busy she had not gotten to nail care needs for residents "lately".

Second interview with Resident #2 on 06/22/22 at 11:09am revealed that a staff member had cut and cleaned his nails today because he asked her to do it.

Interview with a second PCA on 06/22/22 at 12:19pm revealed:
-A resident's nails would be checked, cleaned and clipped by the PCA during his bath or shower.
-Resident #2 would get his personal care needs completed on third shift.
-Third Shift was 11p-7a. She did not work third shift.
-The first shift PCA cut and cleaned Resident #2's nails today once requested by Resident #2.
-It was the responsibility of the third shift PCA to provide nail care needs for Resident #2.
-Third shift was not doing the task.

Interview with Primary Care Physician (PCP) for Resident #2 on 07/12/22 at 4:39pm revealed:
-Resident #2 had left side mobility limitations with his left hand, arm and leg.
-She was not aware Resident #2 had dirt under his fingernails, jagged fingernails and that his nail care needs were not being completed.
-She would be concerned if Resident #2's nails were not being cleaned daily and trimmed routinely; it was not hygienic to have excess dirt

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under any resident nails.
-Resident nails should be cleaned daily and trimmed weekly to biweekly as needed.
-Jagged nails put the resident at risk of obtaining a hangnail, which could be painful.
-Resident #2's left hand was contracted and if nail care was not well maintained, he would be at risk of his fingernails cutting into the skin of his palm and potentially causing an infection from contamination.

Interview with the Special Care Unit (SCU) Coordinator on 07/12/22 at 5:06pm revealed:
-Nail care was a personal care task, which was to be completed by Personal Care Aide (PCA) and Medication Aide (MA) staff.
-The staff was expected to document when the task was completed.
-When a resident refused personal care the PCA or MA was expected to document.
-Resident #2 was known to refuse personal care tasks.
-She was aware that his nails were dirty, long and jagged.
-It was the residents' right to refuse care.
-Excess dirt under his fingernails could result in an infection.
-She was aware of the limitations with Resident #2's left side and the contracting hand.
-If his nails were not cleaned and trimmed regularly then his fingernails could cut into his skin and this would potentially lead to an infection.

Interview with the Executive Director on 07/12/22 at 5:52pm:
-Personal care tasks were assigned to PCA staff to perform.
-Nail care was expected to be completed daily by PCA and MA staff, the SCU Coordinator would

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D 269	Continued From page 30 assist when needed. -If a resident was diabetic than the nail care needs would be provided by the area clinical director nurse for the facility. -She was at the facility once a week and more often if needed. -The PCP was also available to cut resident nails. -The facility staff provided a "spa day" for residents where they focused on residents' nails one to two days a week. -Nail care and other personal care tasks were expected to be documented on the care logs. -There was no shower or bathing schedule for residents. -Residents were provided care according to their care plan. -Residents had the right to refuse care and services and it was expected for refusals of care to be documented and reported to the MA. -If Resident #2's nail care needs were not met then his nails would cut into the skin of his palm once they got too long and he would be at risk of infection.	D 269		
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: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 3 sampled residents (#3) related to not obtaining a referral for physical therapy and occupational therapy for muscle weakness.	D 273		

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D 273	Continued From page 31 The findings are: Review of Resident #3's current FL-2 dated 06/13/22 revealed: -Diagnoses included dementia with behavioral disturbances, physical deconditioning and history of metatisic lung cancer with brain metatsis. -She was intermittently disoriented and was semi-ambulatory. Review of a primary care physician (PCP) electronic progress note dated 06/09/22 revealed: -Resident #3 was seen for an initial visit. -Resident #3 complained that she felt achy and her feet and thighs hurt. -Treatment plan for Resident #3 included physical therapy (PT) and occupational therapy (OT) to evaluate and treat as indicated due to muscle weakness. Review of an electronic progress note dated 06/09/22 at 1:00pm revealed the special care unit (SCU) coordinator documented that she spoke with Resident #3's PCP and obtained new orders. The Executive Director (ED) and SCU coordinator were unable to provide documentation that Resident #3 had been referred for PT and OT on 07/11/22 or 07/12/22. Interview with the SCU coordinator on 07/12/22 at 5:06pm revealed: -She was not aware that Resident #3's PCP had ordered PT and OT on 06/09/22. -She should have noticed the referral from the PCP note but overlooked it. -Resident #3 would have benefited from PT and OT to help strengthen her muscles.	D 273		

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D 273	Continued From page 32 Interview with the ED on 07/12/22 at 5:45pm revealed: -She was not aware that Resident #3's PCP had ordered PT and OT. -She was not aware that there was not any documentation of an order by the PCP for PT and OT for Resident #3. -It was the responsibility of the SCU coordinator and the Area Clinical Director to ensure all orders had been completed. Telephone interview with Resident #3's PCP on 07/12/22 at 2:05pm revealed: -Resident #3 had muscle weakness and complained on feeling achy on 06/09/22 -She was not aware that the facility had not referred Resident #3 for PT and OT on 06/09/22. -She ordered PT and OT for Resident #3 to help improve her muscle weakness. -The facility was responsible for ensuring that her orders were implemented.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the 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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#3)	D 358		

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related to a topical medication for pain.

The findings are:

Review of Resident #3's current FL-2 dated 06/13/22 revealed:
-Diagnoses of dementia with behavioral disturbances, physical deconditioning and history of metastatic lung cancer with brain metastasis.
-She was intermittently disoriented and was semi-ambulatory.

Review of a discharge summary from the Emergency Room (ER) dated 06/09/22 revealed Resident #3 was seen at the ER on 06/09/22 for pain and was started on Diclofenac Sodium 3% gel at discharge; apply twice a day for pain as needed.

Review of a primary care physician (PCP) electronic progress note dated 06/09/22 revealed Resident #3 was seen for an initial visit; she complained that she felt achy and her feet and thighs hurt.

Review of Resident #3's electronic progress note from the PCP dated 06/21/22 revealed:
-Resident #3 complained her entire body hurt and she was unable to rest.
-Resident #3 was seen at the ER on 06/09/22 for pain and was started on Diclofenac Sodium 3% gel at discharge; apply twice a day for pain as needed.
-The PCP documented to continue current treatment plan.

Review of Resident #3's June 2022 electronic medication administration record (eMAR) revealed Diclofenac Sodium 3% gel was not listed on the eMAR.

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D 358	Continued From page 34 Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/12/22 at 4:31pm revealed they had not received an order for Diclofenac Sodium 3% gel from the facility. Interview with the special care unit (SCU) coordinator on 07/12/22 at 5:06pm revealed: -She was not aware that the ER had ordered Resident #3 Diclofenac Sodium 3% gel on 06/09/22. -She and the medication aides (MAs) were responsible for faxing orders from the hospital to the pharmacy after a resident returned from the hospital. -She was not sure how she and the MAs overlooked the order for Diclofenac Sodium 3% gel on 06/09/22. -The Executive Director usually checked behind all the orders to ensure residents did not miss any medications. Telephone interview with Resident #3's PCP on 07/12/22 at 2:05pm revealed: -Resident #3 had muscle weakness and complained on feeling achy on 06/09/22 -She was not aware that the facility had not ordered Diclofenac Sodium 3% gel to treat Resident #3's pain. -She expected the facility to send the order from the ER to the contracted pharmacy. -The Diclofenac Sodium 3% gel should have been available for Resident #3 to help with pain management. Interview with the Executive Director (ED) on 07/12/22 at 5:45pm revealed: -She was not aware that Resident #3 did not have Diclofenac Sodium 3% gel available. -The MA or SCU coordinator were responsible for	D 358		

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D 358	Continued From page 35 faxing or emailing the order to the pharmacy when a resident returned from the hospital. -Resident #3 should not have been without pain medication ordered; she needed to be comfortable and pain free.	D 358		