

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL078101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 08/09/2016
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NAME OF PROVIDER OR SUPPLIER PARKTON PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1165 WEST PARKTON TOBEMORY RD PARKTON, NC 28371
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D 000	Initial Comments The Adult Care Licensure Section and the Robeson County Department of Social Services conducted an annual survey and complaint investigation on 8/3-5/16 and 8/8-9/16. The complaint investigation had been initiated by the Robeson County Department of Social Services on 7/6/16.	D 000		
D 072	<p>10A NCAC 13F .0305(m) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the yard was free from spilled sewage, the grass was cut around the septic tank system and trash was picked-up in the yard.</p> <p>The findings are:</p> <p>Observation at an exit door from the back hall on 08/03/16 at 4:32 p.m. revealed: -There was a blue mattress with the plastic covering torn exposing beige foam material. -Pine straw was on top of the mattress -There was a large ant mound adjacent to the mattress -The mattress was on the ground to the left of the outside stairs approximately 5 feet from the</p>	D 072		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 072	<p>Continued From page 1</p> <p>bottom step.</p> <p>Interview with a resident on 08/03/16 at 4:35 p.m. revealed:</p> <ul style="list-style-type: none"> -The mattress had been there a week or longer. -The mattress belonged to a resident at the facility. -Staff members placed the mattress there to clean the mattress because the resident soiled the mattress with feces. <p>Interview with a housekeeper on 8/05/16 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> -The mattress on the ground outside belonged to an incontinent resident. -The resident had soiled the mattress heavily in feces. -Two personal care aides took the mattress outside and washed it down with bleach. -The mattress had been outside for a few weeks. -The personal care aides should have brought the mattress back into the facility. -The resident was given another mattress from an unoccupied bed. <p>Observation of the yard near the septic system on 8/4/16 at 12:30pm revealed:</p> <ul style="list-style-type: none"> - The grass surrounding the septic system was almost knee high. - On the right side of the septic system there were 3 areas in the grass which were pools of black sludge. -The box which held the electronic pump (on top of the septic system had a red bulb which was not lit up. -The motor of the pump was not running and there was no sound heard. <p>Review of the facility's citation report dated 8/4/16 from the local health department included:</p>	D 072		

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D 072	<p>Continued From page 2</p> <p>-Under the perform maintenance section, the area around the septic tank needed to be maintained.</p> <p>-The violation was to be brought back into compliance by 9/5/16.</p> <p>Interview with the local health inspector on 8/4/16 at 12:30pm revealed:</p> <p>-The sludge was back up from the septic system.</p> <p>-The pump was not working at all, because if it was just malfunctioning, the red light would be blinking, but the pump had no power.</p> <p>Observation of the back deck, which was the designated smoking area, on 8/05/16 at 1:30pm revealed:</p> <p>-Red fire ants were on the deck near the rails on the right side.</p> <p>-There were greater than 100 ants crawling on the deck.</p> <p>Observation on 8/05/16 at 1:30pm revealed a medium sized ant hill was on the ground next to the right side of the deck, which was near the septic tank.</p> <p>Observation on 8/05/16 at 1:50 p.m revealed a staff member was spraying the fire ants with an ant spray on the back deck.</p> <p>Observation on 8/05/16 at 2:00 p.m. revealed:</p> <p>-Ants were crawling across the side walk, which led to the front porch.</p> <p>-An Executive Director from a sister facility went and got the ant spray and started spraying the ants.</p> <p>Interview with a second and a third resident on 8/05/16 at 5:30pm revealed:</p> <p>-Fire ants have been crawling on the deck near</p>	D 072		

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D 072	<p>Continued From page 3</p> <p>the rails on the right side of the deck, for about 1 week.</p> <ul style="list-style-type: none"> -The residents were not aware of any residents being bit by the ants. -The residents stayed away from the ants. -The residents did not know if staff was aware of the ants on the deck or the ant hill on the ground near the deck. <p>Observation of the left side of the yard on 8/08/16 at 6:00pm revealed:</p> <ul style="list-style-type: none"> -A boot and 2 empty soda cans were on the left side of the ramp. -An empty water bottle, an empty soda can and a plastic glove were on the right side of the ramp. <p>Interview with the facility's Administrator on 8/09/16 at 1:10pm revealed:</p> <ul style="list-style-type: none"> -The facility's licensee was responsible for keeping the grounds mowed and cleaned, but only occasionally provided payment for mowing services. -The residents occasionally picked up trash outside of the building, but were not required to do so. -She was not aware of the old mattress near the outside of the right exit door of the back hall, but it should not have been put there. -The building owner was responsible for keeping the grass mowed behind the fence in the septic system area. 	D 072		
D 074	<p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(1) have walls, ceilings, and floors or floor</p>	D 074		

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D 074	<p>Continued From page 4</p> <p>coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls, ceilings, floors and floor coverings were kept clean and in good repair in 2 resident rooms, 6 shared resident restrooms, 4 of 4 shared and common shower rooms, 4 of 5 hallways, 1 community room on the back hall, the dining room, the laundry room and the hopper room ceiling.</p> <p>The findings are:</p> <p>Observations upon entrance in the facility on 8/3/16 at 11:00 a.m. revealed: -The facility had a front, middle and back hall. -The right side of the front hall was the blue hall and the left side of the front hall was the yellow hall. -The right side of the back hall was the pink hall and the left side of the back hall was the yellow hall.</p> <p>Interview with a resident at the front entrance upon arrival and prior to entering the facility on 08/03/16 at 11:00 a.m. revealed: -The resident was concerned about the conditions of the facility. -The toilets did not work. -There was water standing in the halls and in resident rooms.</p> <p>Interview with the Resident Care Coordinator (RCC) on 08/03/16 at 11:10 a.m. revealed: -The water in the common shower rooms, restrooms and hallways was coming from a sewage problem. -The water problem started yesterday.</p>	D 074		

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D 074	<p>Continued From page 5</p> <ul style="list-style-type: none"> -A plumber was at the facility yesterday and thought something may be broke in the septic system. -The plumber was supposed to return today. -Water had been standing on the floor since yesterday. <p>Observation on the front blue hall of the facility on the initial tour on 08/03/16 at 11:15 a.m. revealed:</p> <ul style="list-style-type: none"> -There were large areas of water in the hallway. One of the water puddles covered approximately a fourth of the floor at the doorway leading into resident room #8. -There was a wet, saturated blanket on the bedroom floor at the entrance of the bathroom in room 8. -There were scattered wet areas on the bedroom and restroom floor in room 8. -There was a wet, mildewed odor throughout the hall. <p>Observation of a common bathroom on the right side of the front blue hall on 08/03/16 at 11:18 a.m. revealed:</p> <ul style="list-style-type: none"> -The tub was stained with a yellow orange build up. -There was a tiled frame around the tub, at the foot of the tub, the tiled frame was cracked. <p>Observation of the walls in the shared restroom in room 8 on 08/03/16 at 11:21 a.m. revealed:</p> <ul style="list-style-type: none"> -There were scattered pieces of yellowish beige wall covering/paint peeling away from the tiled wall. -The peeled pieces of yellow beige wall covering were on the floor around the toilet and sink. -There were pieces of the peeling, dangling yellow beige wall covering/paint on the floor. <p>Observation of the blue hall on 8/3/16 at 11:25</p>	D 074		

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D 074	<p>Continued From page 6</p> <p>a.m. revealed a mattress was in the middle of the hall near a puddle of water.</p> <p>Observation on the blue front hall on 08/03/16 at 11:25 a.m. revealed 2 staff members were mopping up the water from the hallway.</p> <p>Interview with the resident who resided in room 8 on 08/03/16 at 11:33 a.m. revealed: -The water on the floors occurred yesterday. -The water was coming from the toilet pipes. -She was unable to use her toilet; the toilet would not flush. -The only resident toilet that worked was a man's restroom and she was uncomfortable using that toilet, but had no choice. -The walls had been peeling since she moved here in March 2016.</p> <p>Interview with the RCC on 08/03/16 at 11:50 a.m. revealed: -She had not made any plans to get the residents moved off the front blue hall. -The back hall was the only area that did not have water leaking on the floor.</p> <p>Observation of a hall light fixture on the front blue hall on 08/05/16 at 6:55 p.m. revealed: -There was no cover over the fluorescent bulbs. -The fixture was hanging approximately 12 inches from the ceiling by wires. -There was a square hole in the ceiling above the lights. The wires from the light were coming from the center of the hole.</p> <p>-Observation of the wall/floor under a water fountain on the front yellow hall on 08/03/16 at 1:00 p.m. revealed there was an irregular gaping space/hole approximately 2 feet long with broken, loose pieces of cement graveled material located</p>	D 074		

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D 074	<p>Continued From page 7</p> <p>behind a dull white painted area and adjacent to the wall.</p> <p>Observation of shower room #1 on the front yellow hall on 08/03/16 at 1:10 p.m. revealed: -2 walls in the shower stall had a solid covering of a thick reddish/black build up ranging in an area from approximately 1/2 foot to 2 feet high from the floor. -There were scattered areas of black grime that trailed along the indented lines of the wall. -There was not a shower nozzle connected to the pipe in the shower stall. -When the water was turned on, the water gushed out with projected force. -There was an uneven space, with no tile or top flooring, that covered the entire length of the shower room entrance approximately 1 inch to 6 inches in width and exposed the under layer of the buildings floor.</p> <p>Observation of the front yellow hall on 08/03/16 at 1:18 p.m. revealed the floors throughout the hall had black scuff marks and multiple areas where old wax appeared to be peeling off that left a black grey dull finish.</p> <p>Observation of a shared resident restroom in room 1 on the front yellow hall on 08/03/16 at 1:24 p.m. revealed: -There was a musty, urine odor in the bathroom. -There was a build- up of white, gray matter around the faucet handles.</p> <p>Observation in a shared resident restroom in room 19 on the middle hall on 08/03/16 at 4:40 p.m. revealed: -The hot water control would twist without a stopping point and had to be placed in a certain position to allow water to flow through the fixture.</p>	D 074		

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D 074	<p>Continued From page 8</p> <p>-The toilet had yellowish orange water in the bowl.</p> <p>Observation of the back halls on 08/03/16 at 4:30 p.m. revealed:</p> <p>-The floors throughout the hall had black scuff marks and multiple areas of old wax peeling off that left a black grey dull finish.</p> <p>-On the back pink hall, there were multiple scattered concentrated areas that were heavily soiled with a black build up that had adhered to the floor.</p> <p>- On the back yellow hall, there was an open square area on the interior wall of the community room approximately 3 feet long that had jagged edges with loose pieces of cement material that exposed an inner layer of gray cinder block type brick.</p> <p>Observation of the restroom in resident room 31 on the back hall on 08/03/16 at 5:10 p.m. revealed:</p> <p>-There was peeling paint on the wall beside the commode.</p> <p>-There were orange yellow stains on the floor.</p> <p>Observation of the restroom in resident room 34 on the back hall on 08/03/16 at 5:15 p.m. revealed:</p> <p>-There was a build- up of white, gray and green matter around the faucet handles.</p> <p>-There were grey and black scuff marks on the floor in front of the toilet.</p> <p>Observation of the restroom in resident room 40 on the back hall on 08/03/16 at 5:20 p.m. revealed:</p> <p>-There were missing pieces and cracks in the flooring.</p> <p>-There were black scuff marks and darker black patterned lines scattered on the restroom floor.</p>	D 074		

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D 074	<p>Continued From page 9</p> <p>Observation of resident room 3 on the front yellow hall on 08/09/16 at 6:30 p.m. revealed: -There were 2 black scuff mark lines along a sheet rocked wall of the room ranging approximately 1 1/2 - 2 feet from the floor. -There were 2 black scuff mark lines approximately 1-2 feet from the floor along the cement wall of the room.</p> <p>Interview with the Administrator on 08/03/16 at 5:30 p.m. revealed: -She was aware that the floors throughout the facility were in need of much attention. -They had attempted to strip and re-wax the floors about 5 months ago when she first started at the facility but were unable to complete the task. -She was aware that the facility needed repairs and painting. -There were 2 housekeepers at the facility who were responsible for cleaning. They work on alternating days, about 5 hours per day. -They had a problem with hard water rust at the facility. -The RCC and the Administrator were responsible for supervising the housekeeping staff. -The RCC and or the Administrator monitored housekeeping tasks every Monday by looking in the rooms. -Staff members were not very motivated lately due to payroll issues within the facility,</p> <p>Interview with a staff person from the local health department on 08/04/16 at 11:35 a.m. revealed: -She had observed the shower rooms today and it appeared no one had been cleaning. -The black and orange build up in the shower stalls was due to a microbial growth. -She was in the facility February 2016 and had no</p>	D 074		

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D 074	<p>Continued From page 10</p> <p>concerns of the cleanliness of the facility. -She would speak with the RCC and advise them to clean with a bleach and water mixture immediately.</p> <p>Interview with the RCC on 08/04/16 at 11:40 a.m. revealed: -The facility did have a supply company that provided cleaning products. -The supply company "cut them off" because the facility had not paid the company for past services.</p> <p>Interview with a housekeeper on 08/04/16 at 12:30 p.m. revealed: -She received her training from another housekeeping staff member. -When she started, she was not trained on which cleaning products were to be used for specific cleaning needs. -The previous Administrator kept cleaning supplies in the facility to use by ordering the supplies however the current Administrator did not. -There were times she had very little cleaning products for cleaning. -When she needed cleaning supplies, she would tell the RCC or Administrator. -The RCC and the Administrator would go to a local store for supplies. -There were a few days last month the facility was out of cleaning products, so she bought her own cleaning supplies. -She did not report to the RCC or Administrator that the facility was out of cleaning products. -They do not have a written schedule on when, where or how often to clean. -When she first started someone came to the facility and taught them how to mix bleach and water and to always label the bleach and water</p>	D 074		

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D 074	<p>Continued From page 11</p> <p>mixture container.</p> <ul style="list-style-type: none"> -She was not given any instructions on how to measure the bleach and water ratio to be used for cleaning. -The facility had cleaning brushes, mops, and brooms but the cleaning needs of the facility did not require the use of the brushes. -She had not been given any expectations from the current administrator or RCC of the facility's cleaning needs and would clean in areas she thought needed cleaning. -They try to wipe down walls in resident areas but it is hard because the walls have peeling paint and needed painting. -She would clean the shower stalls with a spray bottle of bleach and water. -Housekeeping scrubbed the walls in the shower stall but this was done not often. -There was no bleach at the facility today. -Bleach was an item that she and the other housekeeper bought. <p>Interview with the RCC on 08/05/16 at 9:40 a.m. revealed:</p> <ul style="list-style-type: none"> -The leaser had provided money on 08/04/16 to purchase groceries and cleaning supplies. -She would do the shopping today. <p>Interview with a second housekeeper on 08/05/16 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> -Housekeeping staff reported issues/concerns to the RCC. -The back halls were in bad shape because that section of the facility was closed down a few months ago because there were not enough residents at the facility. -There were men painting and cleaning the floor a few months ago, but they stopped. She was unsure why. -She felt a lot of the black grime and build up was 	D 074		

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D 074	<p>Continued From page 12</p> <p>coming from no ventilation in the shower rooms. -She had not worked on a regular schedule at the facility in about a month because her pay checks were bouncing. -There was no cleaning schedule for the facility. She cleaned as she saw the need in areas that needed cleaning.</p> <p>Interview with RCC on 08/05/16 at 7:15 p.m. revealed: -She had met with one of the housekeepers in the past related to that staff member's quality of work. -One of the staff members in housekeeping was upset because their work hours were cut.</p> <p>Observation of the community shower room, located on the front, right hall (blue) on 8/03/16 at 12:40pm: -The floor and tiled walls of the shower had a thick reddish-brown grime with black, mold-like areas on the floor half way up from the bottom. -There were 2 puddles of water on the floor. -The backside of the toilet was on the wall. The inside of the toilet had urine and feces. -The wall under the sink had cracked paint. -There was a musty smell throughout the shower room.</p> <p>Observations of the back hall on 8/03/16 from 11:15 a.m. to 1:00 p.m. revealed: -The shower in the community on the back hall had pieces of tile missing from the floor. Three large white strips were on the floor of the shower. The shower had brown stains on the tile throughout the shower. -The toilet seat, located in an empty room near the smoking deck, had blood on it.</p> <p>Observation of the hopper room on 8/08/16 at 12:00pm revealed:</p>	D 074		

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D 074	<p>Continued From page 13</p> <ul style="list-style-type: none"> -The entire "popcorn" ceiling was covered in black soot. -The light fixture was hanging from the ceiling with the wires exposed. Black soot from the ceiling was attached to the light fixture. -Two large pieces of the black soot from the "popcorn" ceiling was missing. -One large piece of the "popcorn" ceiling was hanging from the ceiling. -A piece of the "popcorn" ceiling (2 feet) was on the counter covered in black soot. <p>Interview with the RCC on 8/8/16 at 11:58am revealed:</p> <ul style="list-style-type: none"> -There was a fire in the hopper room in March or April 2016. -The smoke came from the exhaust fan in the ceiling in the hopper room and caused the black ceiling. -She was aware of the wires hanging from the ceiling in the hopper room. -Staff did not use the hopper room and it was not connected to anything electrical. -Someone was supposed to have come to the facility on last week and start construction on the sheet rock and the wires, but they had not come to the facility. <p>Interview with the facility's Administrator on 8/9/16 at 1:10pm revealed:</p> <ul style="list-style-type: none"> -There was a fire in the hopper room in April, 2016. -The repairs have not been completed because the building owner and facility licensee have not provided the payment for the services. - The electrician refused to repair the electrical wiring in the hopper room because the licensee had an unpaid bill for previous electrical services. 	D 074		

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D 074	<p>Continued From page 14</p> <p>Interview with a facility housekeeper on 8/03/16 at 12:50pm revealed:</p> <ul style="list-style-type: none"> - The bathrooms were cleaned every day if there were cleaning supplies. -The facility was usually out of cleaning supplies. -There was no bleach or disinfectant available for cleaning. -Staff had to buy their own cleaning supplies, because the facility would not purchase supplies. -It was difficult for the staff to continue to buy supplies, because the staff was not getting paid. The paychecks could not be cashed due to insufficient funds. - The housekeeper was not aware the community showers had black grim/mold on tile and floors. -The bathrooms on the back halls were not cleaned, because there were no residents staying on the back hall. <p>Interview with a resident on 8/03/16 at 12:45pm revealed:</p> <ul style="list-style-type: none"> -Since yesterday, the community bathroom commodes flushed water in the hallway (front hallway). -He had to be careful when walking in the hallway to keep from slipping in water. -The community shower on the front hall had black mold on the floor and walls of the shower. <p>Interview with a second resident on 8/03/16 at 12:50pm revealed:</p> <ul style="list-style-type: none"> -The community bathrooms needed cleaning and repairing. -When the commodes were flushed, water ran out of bathrooms into the hallway. -The paint was peeling off the bathroom walls and mold was growing in the showers. -The resident did not like walking through the water in the hallways and in the bathroom 	D 074		

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D 074	<p>Continued From page 15</p> <p>because it "may be nasty".</p> <p>Interview with a third resident on 8/03/16 at 2:10pm revealed the commode in the resident's bedroom has been "stopped up" for 2 days.</p> <p>Interview with a fourth resident on 8/03/16 at 1:05pm revealed: -The commode in the resident's bathroom had been overflowing for the last 2 days when flushed. -The housekeeper turned the water off to the bathrooms yesterday (8/2/16).</p> <p>Interview with the facility's Administrator on 8/9/16 at 1:10pm revealed: -The 2 facility housekeepers were responsible for daily cleaning of the bathrooms, including residents' bathrooms and community bathrooms on the front and back halls. -She was aware there was a mold/mildew problem in the showers 2 months ago. Bleach and other cleaning supplies were bought for the housekeepers to clean the showers, but apparently cleaning the showers was not done. -The problem was reported to the Administrator, but she did not go to the bathroom and observe mold/mildew. -The Administrator and RCC were responsible for supervising the housekeeping staff, and if both were not in the building, the medication aide/supervisor was responsible for supervising housekeeping staff. -The Administrator was aware of the black grime on the back hallway floors which was there when she started to work at the facility in February 2016. -A cleaning company had started to strip and re-wax the floors a few months ago, but they only completed the dining room. The building owner</p>	D 074		

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D 074	Continued From page 16 did not pay for the services and the company refused to finish without payment.	D 074		
D 105	<p>10A NCAC 13F .0311(a) Other Requirements</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations and interviews, the facility failed to assure the facility's septic tank system had been maintained in a safe and operating condition resulting in sewage not properly flushing causing water to back-up in showers, commodes and the facility's washing machine.</p> <p>The findings are:</p> <p>1. Observations upon entrance in the facility on 8/3/16 at 11:00 a.m. revealed: -The facility had a front, middle and back hall. -The right side of the front hall was the blue hall and the left side of the front hall was the yellow hall. -The right side of the back hall was the pink hall and the left side of the back hall was the yellow hall. -Water was in the middle of the floor on the blue hall.</p> <p>Interview with a resident on 8/3/16 at 11:00 a.m. revealed the toilets were overflowing and backing up and the residents could not take a shower.</p>	D 105		

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D 105	<p>Continued From page 17</p> <p>Interview with another resident on 8/03/16 at 12:45pm revealed: -Since yesterday, the community bathroom commodes flushed water in the hallway (front hallway). -He had to be careful when walking in the hallway to keep from slipping in water.</p> <p>Interview with a third resident on 8/03/16 at 12:50pm revealed: -When the commodes were flushed, water ran out of bathrooms into the hallway. -The resident did not like walking through the water in the hallways and in the bathroom because it "may be nasty".</p> <p>Interview with a fourth resident on 8/03/16 at 1:05pm revealed: -The commode in the resident's bathroom had been overflowing for the last 2 days when flushed. -The housekeeper turned the water off to the bathrooms yesterday (Tuesday).</p> <p>Interview with a fifth resident on 8/03/16 at 2:10pm revealed the commode in his bedroom has been "stopped up" for 2 days.</p> <p>Interview with the Resident Care Coordinator (RCC) on 8/3/16 at 11:02 a.m. revealed the water was on the floor in the facility, because there was a problem with the septic system.</p> <p>Interview with a representative from the Division of Health Service Regulation (DHSR) Construction section on 8/3/16 at 3:00 p.m. revealed: -The septic system pumps were turned off.</p>	D 105		

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D 105	<p>Continued From page 18</p> <p>-The leaks in the pump had oversaturated the "field."</p> <p>Interview with a representative from DHSR Construction section on 8/3/16 at 3:30 p.m. revealed he told the RCC on 8/3/16 the septic tank needed to be pumped.</p> <p>Observations on 8/3/16 at 4:07 p.m. revealed: -A local septic tank company had come to the facility to empty the septic tank. -From 4:07 p.m. to 7:00 p.m., the local septic tank company had made at least 5 trips to the facility to empty the septic tank.</p> <p>Interview with a resident on 8/4/16 at 8:20 a.m. revealed: -The bathrooms and showers are now working. -The "guy with the truck" was here until 9:30 p.m. last night pumping the tank.</p> <p>Observation on 8/4/16 at 9:00 a.m. revealed the local septic tank company had come to the facility to empty the septic tank.</p> <p>Interview with a local health inspector on 8/4/16 at 10:45 a.m. revealed: -The septic tank was finally getting pumped out "like it should." -The septic tank holds "around" 10,000 gallons of sewage. -A local plumber was checking out the control panel of the pump to get it fixed -The plumber should have the panel repaired. -Until the panel was repaired, the facility should "pump and haul" every three days until the control panel was repaired. -The box around the septic tank control panel was full of ants and the plumber was having a problem trying to get to the box.</p>	D 105		

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D 105	<p>Continued From page 19</p> <p>Observation of the septic system on 8/4/16 at 12:30pm revealed: -On the right side of septic system there were 3 areas in the grass, which were pools of black sludge. -The box, which held the electronic pump on top of the septic system, had a red bulb which was not lit up. -The motor of the pump was not running and no sound was heard.</p> <p>Interview with the local health inspector on 8/4/16 at 12:30 pm revealed: -The sludge was due to back up from the septic system. -The pump was not working at all, because if it was just malfunctioning, the red light would be blinking. -The pump had no power.</p> <p>Review of the citation report dated 8/4/16 from the local health department revealed: -Under the other repairs section, "A contractor was to repair the pump tank". -Under the perform maintenance section, "The facility was to start pump and haul every 3 days of the septic tank and provide documentation until the issue is resolved. The area around the septic tank needs to be maintained". -The violation was to be brought back into compliance by 9/5/16.</p> <p>Interview with the facility's contracted plumber on 8/04/16 at 2:00pm revealed: -The 2 electric sewage pumps, which pumped the sewage from the facility's septic tank, were not working. -He did not know how long the pumps were not</p>	D 105		

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D 105	<p>Continued From page 20</p> <p>working, but based on the condition of the pump, which was filled with ants, both had not worked for a few months.</p> <ul style="list-style-type: none"> -The pumps appeared to have been struck by lightning. -The septic system will need to be pumped out as soon as possible. <p>Interview with the contracted plumber on 8/04/16 at 6:43pm revealed:</p> <ul style="list-style-type: none"> -He installed a pump that was sufficient to run the septic tank system. -The local septic tank company was trying to get the bottom of the tank cleaned. <p>Interview with the local health inspector on 8/05/16 at 10:05am revealed:</p> <ul style="list-style-type: none"> -One of the pumps in the tank was working. -The other pump needed to be fixed. -The local plumber was trying to fix the other pump and control panel. -The facility could have the "pump and hall" for now. <p>Interview with the RCC on 8/08/16 at 12:38pm revealed the contracted plumber installed the new septic tank pumps and the septic tank alarm over the weekend (8/6-7/16).</p> <p>Interview with the facility's Administrator on 8/09/16 at 1:10pm revealed:</p> <ul style="list-style-type: none"> -When she started working at the facility in February 2016, she was already aware of septic system problems. -The large concrete cover over the septic system was cracked and needed to be replaced and the health inspector informed the building owner. -The cover was replaced 2 months later after the middle line form the septic system became clogged and had to be cleaned out. 	D 105		

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D 105	<p>Continued From page 21</p> <ul style="list-style-type: none"> -Last Tuesday (8/2/16) after the commodes and showers backed up and overflowed, a plumber came to the facility at 5:00pm but did not repair the problem and the staff were not to flush front bathrooms or use showers. -The Administrator was not aware the septic system pump was not working. <p>Interview with the facility's contracted plumber on 8/09/16 at 6:00pm revealed:</p> <ul style="list-style-type: none"> -Everything was fixed. -Two new pumps were put in the septic tank system. -The drain line was fixed. -Tomorrow the only thing left to do was to put up the cedar block. <p>2. Interview with the Resident Care Coordinator (RCC) on 08/03/16 at 11:10 a.m. revealed:</p> <ul style="list-style-type: none"> -The staff had been unable to do laundry since 08/02/16 because of the sewer line problems in the building. -A plumber was in the facility yesterday. -The plumber should be coming back today. <p>Confidential interview with a staff member revealed:</p> <ul style="list-style-type: none"> -Some of the residents' clothes would soon be all soiled. -There was enough linens clean for the residents' needs. -The washing machine would not work on the spin cycle. <p>Observation of the laundry room on 08/03/16 at 12:15 p.m. revealed:</p> <ul style="list-style-type: none"> -There was a musty wet smell in the laundry room. -There were large piles of clothes on the floor, counter and in a laundry basket with numerous 	D 105		

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D 105	<p>Continued From page 22</p> <p>pieces of clothing hanging off the edges of the basket and the floor surrounding the basket. -There were several scattered piles of wet blankets and linen on the floor. -There was not a clear walkway to the washing machine due to the soiled linen and clothes.</p> <p>Interview with a resident on 8/03/16 at 12:50pm revealed: -There was never clean towels and washcloths in the facility. -A local church gave the resident 1 washcloth and 2 towels which she kept in her room. -Another resident gave the resident a washcloth and 2 towels which she kept in her room.</p> <p>Observation of the laundry room on 08/04/16 at 9:55 a.m. revealed: -There were clothes, linens and blankets piled on the floor, counter and in a laundry basket. -There was not a clear walkway to the washing machine due to the soiled linen and clothes on the floor. -There was a strong, wet, sour smell. -Two plumbers entered the laundry room and made facial grimaces.</p> <p>Confidential interview with a staff person on 08/04/16 at 11:23 a.m. revealed: -The washing machine was still not working. -She was not aware of any instructions that had been given to staff regarding a plan of action for the residents' laundry needs and may have to take the clothes to the laundry matt.</p> <p>Observation from the hallway close to the laundry room on 08/05/16 at 8:45 a.m. revealed: -The door to the laundry room was partially closed. -There was a strong molding, sour smell in front</p>	D 105		

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D 105	<p>Continued From page 23</p> <p>of the laundry room door.</p> <p>Confidential interview with a resident revealed: -The resident had enough linens and washcloths. -The resident had one set of clothes to wear the next day. -The resident was concerned the clean clothes would be gone after tomorrow.</p> <p>Interview with a staff member on 08/05/16 at 12:40 p.m. revealed: -The staff member attempted to start a load of laundry and the machine worked. -She was washing the loads of clothes through two wash cycles. -There were blankets to be washed that were wet from the toilet water that occurred on 08/02/16.</p> <p>Interview with a technician hired to repair the washing machine on 08/09/16 at 11:10 a.m. revealed: -The washing machine's water valve was defective. -The washing machine's drain had debris caught in it. -The washing machine was fixed now. -There was a short in the control panel, the short posed no danger of fire and can be used until the new control board comes in. -The washing machine was purchased and installed from his company years ago.</p> <p>Interview with the Administrator on 08/09/16 at 7:20 p.m. revealed: -She understood that the washing machine messed up this past Wednesday on 08/03/16 and a repair company was coming. -The facility just had the machine fixed a few weeks ago. -The Resident Care Coordinator was responsible</p>	D 105		

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D 105	<p>Continued From page 24</p> <p>for contacting the repair company to work on the washing machine.</p> <hr/> <p>Review of the Plan of Protection provided by the facility on 8/5/16 revealed:</p> <ul style="list-style-type: none"> -Immediately, the local plumber was called to the facility to come and look at the septic system. -The local plumber will be at the facility on 8/8/16 to continue repairing the septic system. -One of the septic pumps was repaired on 8/4/16. -The washing machine started back working on 8/4/16. -The local plumber will put a new septic pump alarm on the side of the building, which will alarm when the septic system was malfunctioning. -Staff will be trained to monitor the septic system and report any problems to the Resident Care Coordinator (RCC). -The RCC will monitor the septic system and the laundry machine weekly to make sure it was working properly. <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 8, 2016</p> <p>/</p>	D 105		
D 113	<p>10A NCAC 13F .0311(d) Other Requirements</p> <p>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</p>	D 113		

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D 113	<p>Continued From page 25</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 6 of 15 fixtures.</p> <p>The findings are:</p> <p>Observation of the hot water temperature in the shower room #1, located on the front yellow hall on 08/03/16 at 1:10 p.m. revealed the water temperature was 146 degrees F.</p> <p>Interview with the Resident Care Coordinator (RCC) on 08/03/16 at 1:22 p.m. revealed: -She was not aware of any issues with the hot water being too hot in shower room #1 on the yellow hall. -She would place a caution hot water sign up immediately.</p> <p>Observation on 08/03/16 at 1:30 p.m. revealed staff had placed a "do not use sign" at the entrance door of shower room #1.</p> <p>Observation of the water temperatures in resident room #19 on 8/03/16 at 4:40 p.m. revealed the hot water temperature in the sink was 128 degrees F.</p>	D 113		

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D 113	<p>Continued From page 26</p> <p>Interview with Administrator on 08/03/16 at 3:40 p.m. revealed: -She would have "caution hot water" added to the "do not use" sign in shower #1. -She would have maintenance see if they can turn the hot water down.</p> <p>Observation on 8/03/16 between 5:10 p.m. and 5:25 p.m. revealed the following water temperatures: -At 5:10 p.m. in resident room #31, the hot water temperature at the bathroom sink was 98 degrees F. -At 5:15 p.m. in resident room #34, the hot water temperature at the bathroom sink was 90 degrees F. -At 5:20 p.m. in resident room #40, the hot water temperature at the bathroom sink was 88 degrees F.</p> <p>Interview with the RCC on 08/03/16 at 5:25 p.m. revealed: -There had not been any recent issues with water temperatures. -She was not aware of any resident complaints related to the temperature of the water being too hot or too cold. -The facility did have a maintenance man that checked the water temperatures weekly. -The maintenance man resigned about 3 weeks ago. -No one was currently checking the water temperatures in the facility. -The facility did not have a policy in place for checking water temperatures. -She would place a "caution hot water" sign at the sink in Room 19 and add "caution hot water" to shower room #1 on the yellow hall.</p> <p>Interview with the Administrator on 08/03/16 at</p>	D 113		

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D 113	<p>Continued From page 27</p> <p>5:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The facility's maintenance man was responsible for checking water temperatures. -The maintenance man was part time and worked 20 hours every 2 weeks. -The water temperatures were checked weekly. -The facility had issues in the past with hot water temperatures. -The water temperatures were recorded on a weekly temperature log. <p>Review of the weekly temperature logs that began during the 4th week of April 2016 through the 2nd week of July 2016 revealed:</p> <ul style="list-style-type: none"> -There was a space to enter one water temperature weekly under a section labeled water temperatures, main areas (100-116). -The water temperatures ranged between 99-109 degrees. -There was no documentation to reflect which water fixtures were checked. - In April 2016, there was one water temperature documented as 105 degrees in the main areas on 04/26/16. -In May 2016, there were water temperatures documented as 99 degrees in the main areas on 05/04/16, 100 degrees in the main areas on 05/12/16, 101 degrees in the main areas on 05/19/16 and 102 degrees in the main areas on 05/26/16. -In June 2016, there were water temperatures documented as 103 degrees in the main areas on 06/02/16, 104 degrees in the main areas on 06/09/16, 102 degrees in the main areas in 06/22/16, and 104 degrees in the main areas on 06/29/16. -There was no documented water temperatures for the week of 06/12/16. -In July 2016, there were water temperatures documented as 103 degrees in the main areas on 	D 113		

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D 113	<p>Continued From page 28</p> <p>07/07/16 and 109 degrees in the main areas on 07/13/16. There were no other documented water temperatures for July 2016</p> <p>Interview with 2 plumbers hired by the facility to perform repairs on 08/04/16 at 9:50 a.m. revealed:</p> <ul style="list-style-type: none"> -The plumbers felt the issue was related to a missing or faulty check valve. -They would go around the facility to check the hot water heaters. -The plumbers did not have a thermometer to check the water temperatures. -The hot water in the kitchen should be at 140 degrees F. Since shower #1 was located in close proximity with the kitchen, it would be a possible cause for the hot water in shower #1 to be elevated . <p>Observation of the hot water temperature in shower room #1, located on the front yellow hall on 08/04/16 at 9:55 a.m. revealed:</p> <ul style="list-style-type: none"> -The water temperature at the shower was 124 degrees F. -There was no sign on the door not to use or a "caution hot water" sign. <p>Interview with two personal care aides on 08/04/16 at 11:13 a.m. revealed:</p> <ul style="list-style-type: none"> -They were not sure if there was a sign posted on the door for shower room #1 because they had not been down that hall during their shift. -They were told that the residents should not use shower room #1 because the water was too hot. -There was one resident in the facility that mainly used shower #1 and was independent with his bathing needs. -The only concern voiced by residents was that the water temperature at times were not hot enough. 	D 113		

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D 113	<p>Continued From page 29</p> <p>-They always check the water using their ungloved hand prior to getting a resident in the shower to assure the water is at a safe temperature.</p> <p>Observation of the water temperatures in resident room #19 on 8/04/16 at 11:05 a.m. revealed: -The water temperature in the sink was 128 degrees F. -There was a sign posted at the sink, "caution, water hot".</p> <p>Interview with a resident who resided in room #19 on 08/04/16 at 11:05 a.m. revealed he had never noticed the water at the sink being too hot.</p> <p>Interview with the plumber hired by the facility at 08/04/16 at 11:20 a.m. revealed: -They feel the inconsistent water fixture temperatures were related to a missing check valve. -The owner of the plumbing company would come out and assess the water temperature issue.</p> <p>Interview with the RCC on 08/04/16 at 12:10 p.m. revealed she would replace the do not use; caution hot water sign on the door of shower #1.</p> <p>Interview with the RCC on 08/04/15 at 7:30 p.m. revealed: -A sign was placed on shower room #1 but someone had taken the sign down. -She would replace the do not use sign on the door of shower room #1.</p> <p>Interview with the RCC on 08/05/16 at 9:35 a.m. revealed that the owner of the building had hired a different plumber to make the repairing the facility.</p>	D 113		

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D 113	<p>Continued From page 30</p> <p>Observation of shower room #1 on 08/05/16 at 10:38 a.m. revealed: -There was a "do not use" sign on the door. -The hot water temperature was 136 degrees F.</p> <p>Interview with a second hired plumber on 08/05/16 at 10:40 a.m. revealed: -He would check the hot water heaters in the back of the facility to see if the water temperature could be adjusted. -In shower room #1, there were water control valves located approximately 4 feet high on the wall on the opposite side of the shower stall. -The water control valves were dangerous due to the location, making it easy for anyone to turn the cold water off, causing only hot water to filter through the shower fixture. -He could check the hot water heaters in the back for the low temperature readings.</p> <p>Observation of shower #1 on 08/05/16 at 4:55 p.m. revealed the shower room door had tape hung in a criss-cross across the entrance and a sign on the door that read "Do not enter".</p> <p>Observation of resident room 34 on 08/05/16 at 6:40 p.m. revealed the hot water temperature at the bathroom sink was 96 degrees F.</p> <p>Confidential interviews with 4 residents revealed: - The resident never noticed the water being too hot at any of the fixtures. - The hot water on the back hall showers is cool, slow to warm, and never get very hot. - The residents had never been burned by the hot water. -The water temperatures were always cool in the shower rooms on the back hall. -The resident used shower room #1 last evening</p>	D 113		

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D 113	<p>Continued From page 31</p> <p>and the water was real hot; there was a sign on the door not to use; the resident reported the hot water temperature to staff who told him not to use again until the water was repaired; he was not burned by the hot water.</p> <ul style="list-style-type: none"> - He knew how to use the shower faucets to get the water temperature to his preference. <p>Interview with the RCC on 08/05/16 at 7:15 a.m. revealed:</p> <ul style="list-style-type: none"> -She would implement a plan to monitor the water temperatures in the facility. -The staff would be trained on the new process of checking water temperatures. -She would implement a schedule for the water temperature checks and have staff document on a flow sheet. -She was unsure of the correct hot temperature range that should be maintained in resident care areas. -She verbalized an understanding of the appropriate range for hot water temperatures after review of the state regulations. <p>Observation on 08/8/16 at 7:15 p.m. revealed:</p> <ul style="list-style-type: none"> -The Medication Aide and the surveyor calibrated both thermometers. -The surveyor's thermometer read 34 degrees F. -The facility's thermometer read 33 degrees F. <p>Observation in the shower room #1, on the front yellow hall on 08/08/16 at 7:35 p.m. revealed:</p> <ul style="list-style-type: none"> -The door way to the shower #1 remained with tape crossing over entrance and a sign "do not enter". -The facility's thermometer read 138 degrees F at the shower for the hot water. -The surveyor's thermometer read 138 degrees F for the hot water at the shower. 	D 113		

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D 113	<p>Continued From page 32</p> <p>Observation in room #2 on 08/08/16 at 7:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The facility's thermometer read 118 degrees F for the hot water at the sink. -The surveyor's thermometer read 118 degrees F for the hot water at the sink. -There was a "caution, danger water very hot, do not use" on the back of the bathroom door. -The resident said the sign had been there a long time. <p>Review of water temperature log sheets documented as implemented on 08/05/16 revealed:</p> <ul style="list-style-type: none"> -There was an instruction sheet to please check all water temperatures in all communal bathrooms every shift and before resident baths, water temperature range of 100 to 116 degrees F. -There was not a log for 08/07/16. -There was not a log for all 3 shifts. <hr/> <p>Review of the Plan of Protection provided by the facility on 8/05/16 revealed:</p> <ul style="list-style-type: none"> -Immediately, the local plumber was called and will be at the facility on 8/8/16 to fix the high water temperatures -The bathrooms with the high water temperatures were closed to the residents. -Before the residents used the showers or bath, the direct care staff tested the water with a thermometer to make sure the temperatures ranged between 100-116 degrees Fahrenheit. -The Resident Care Coordinator will check the log on 8/08/16 and weekly. <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 8, 2016</p>	D 113		

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D 176	Continued From page 33	D 176		
D 176	<p>10A NCAC 13F .0601 (a) Management Of Facilities</p> <p>10A NCAC 13F .0601Management Of Facilites</p> <p>(a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews and record review, the Administrator failed to assure the total operations of the facility as evidenced by noncompliance related to physical environment, housekeeping and furnishings, other requirements, such as electrical, mechanical and plumbing equipment, hot water temperatures, health care and cleanliness of the food storage areas.</p> <p>The findings are:</p> <p>Interview with the Resident Care Coordinator (RCC) on 8/3/16 at 11:02 a.m. revealed the Administrator was not at the facility.</p>	D 176		

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D 176	<p>Continued From page 34</p> <p>Confidential interview with a staff member revealed the Administrator was not there a lot, mostly she was in and out.</p> <p>Interview with the Administrator on 8/3/16 at 4:03 p.m. revealed: -The RCC met the qualifications to function as the Supervisor. -The census was 21. -Today (8/3/16) was the Administrator's last physical day in the facility. -She was going on vacation until 8/9/16 and her last physical day at the facility would be on 8/10/16. -If staff needed her, she would be available by phone.</p> <p>Interview with a Medication Aide on 8/8/16 at 5:30 p.m. revealed the Executive Director from the sister facility just left a few minutes ago and said he may or may not return to the facility, but he would be available by phone.</p> <p>1. Based on observations and interviews, the facility failed to assure the yard was free from spilled sewage, the grass was cut around the septic tank system and trash was picked-up in the yard. [Refer to Tag D072, 10A NCAC 13F .0305(m)(1).]</p> <p>2. Based on observations and interviews, the facility failed to assure the walls, ceilings, floors and floor coverings were kept clean and in good repair in 2 resident rooms, 6 shared resident restrooms, 4 of 4 shared and common shower rooms, 4 of 5 hallways, 1 community room on the back hall, the dining room, the laundry room and the hopper room ceiling. [Refer to Tag D074, 10A NCAC 13F .0306(a)(1).]</p>	D 176		

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D 176	<p>Continued From page 35</p> <p>3. Based on observations and interviews, the facility failed to assure the facility's septic tank system had been maintained in a safe and operating condition resulting in sewage not properly flushing causing water to back-up in showers, commodes and the facility's washing machine. [Refer to Tag D105, 10A NCAC 13F .0311(a). (Type A2 Violation)]</p> <p>4. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 6 of 15 fixtures. [Refer to Tag D113, 10A NCAC 13F .0311(d). (Type A2 Violation)]</p> <p>5. Based on record review and interviews, the facility failed to notify the resident's primary provider regarding elevated blood pressures, finger stick blood sugar results obtained outside of the established parameters and failed to ensure medical screening refusals were reported to the primary provider for 1 of 4 residents sampled (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b). (Type B Violation)]</p> <p>6. Based on observations and interviews, the facility failed to assure the reach-in cooler, the reach-in freezers, the food storage bins, and the dining room floor, wall and ceiling were cleaned. [Refer to Tag D282, 10A NCAC 13F .0904(a)(1).]</p> <p>7. Based on observation and interviews, the facility failed to assure food was not exposed to cross contamination related to the foods storage, uncovered food and raw meats that were placed in unlabeled, plastic storage bags in the reach-in cooler and freezer and contamination from loose debris on the dry storage bin lids and no bin lid on</p>	D 176		

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D 176	Continued From page 36 one of the dry storage bins. [Refer to Tag D283, 10A NCAC 13F .0904(a)(2).] _____ Review of the Plan of Protection provided by the facility on 8/22/16 revealed: -Immediately, all the rule areas out of compliance will be addressed and corrected. -The Administrator and Resident Care Coordinator will continue communication with the licensee to assure all services rendered will be paid to the serviced companies. -Management will review the monitoring system. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 8, 2016.	D 176		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interviews, the facility failed to notify the resident's primary provider regarding elevated blood pressures, finger stick blood sugar results obtained outside of the established parameters and failed to ensure medical screening refusals were reported to the primary provider for 1 of 4 residents sampled (#1).	D 273		

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D 273	<p>Continued From page 37</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 03/04/16 revealed: -Resident #1's diagnoses included schizoaffective disorder, bipolar type, diabetes, hypertension, hepatitis C, gonorrhea, and history of syphilis. -Resident #1 was intermittently confused. -Resident #1 was ambulatory.</p> <p>Review of the Resident Register for Resident #1 dated 03/04/16 revealed an admission date of 03/04/16.</p> <p>A. Review of Resident #1's physician's orders dated 05/10/16 revealed: -There was an order to schedule an appointment for a mammogram yearly. -There was an order to schedule an appointment for an annual pap smear.</p> <p>Review of Resident #1's diagnostic test results revealed there were no outside screening reports for a mammogram or a pap smear.</p> <p>Review of a radiology clinic itinerary for Resident #1 revealed an appointment for a mammogram on 06/21/16 at 11:15 a.m.</p> <p>Telephone interview with the mammogram screening provider on 08/09/16 at 1:03 p.m. revealed: -Resident #1 was scheduled for an appointment on 06/21/16 at 11:15 a.m. -The appointment was cancelled due to the resident being in the hospital.</p> <p>Interview with the Lead Medication Aide (LMA) on 08/09/16 at 1:30 p.m. revealed: -Resident #1 was scheduled for a mammogram</p>	D 273		

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D 273	<p>Continued From page 38</p> <p>appointment on 06/21/16 at 11:15 a.m. - Resident #1 was scheduled for a Pap smear appointment on 06/21/16 at 9:15 a.m. -She was unsure if Resident #1 went to those appointments, but the transporter would have that information.</p> <p>Interview with the Transporter on 08/09/16 at 1:45 p.m. revealed: -The lead MA was responsible for arranging the appointments for the residents. -She assisted the lead MA in the process of scheduling resident appointments and sending referral information to providers. -She was responsible for driving the residents to their appointments and providing any follow-up information and visit summaries back to the lead MA. -Follow-up information and visit summaries were copied for scheduling purposes and the original went into the resident's chart. -Resident #1 was scheduled for a pap smear on 06/21/16 at 9:15 a.m. -Resident #1 refused to reschedule her mammogram and refused to go to the Pap smear appointment in June 2016. -She reported the resident's refusal to the Resident Care Coordinator (RCC) who advised her to continue to encourage the resident to reschedule the appointments. -Resident #1 had not refused any other medical appointments. -She had spoken with the resident on several occasions to reschedule the Pap smear and mammogram but the resident continued to refuse. -She called and cancelled the appointments for the mammogram and Pap smear. -She documented the appointment refusals in the scheduling calendar book.</p>	D 273		

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D 273	<p>Continued From page 39</p> <p>-She did not inform Resident #1's primary care provider that the resident refused those appointments.</p> <p>Telephone interview with Resident #1's primary care provider on 08/09/16 at 6:00 p.m. revealed: -She was not aware that Resident #1 had refused a mammogram and a Pap smear appointment. -She was not providing care for Resident #1 in May 2016 but should have been informed of the resident's refusals so she could have provided encouragement to reschedule those appointments. -She started the resident's initial care in June 2016.</p> <p>Review of Resident #1's record revealed a signed physician order and an appointment date of 06/24/16 with the current primary provider.</p> <p>Refer to interview with the Administrator on 08/09/16 at 6:00 p.m.</p> <p>B. Review of Resident #1's current FL-2 dated 03/04/16 revealed: -There was an order for finger stick blood sugars (FSBS) twice daily. -There was an order for Levimir 100 units/ml (a long acting insulin used to control high blood sugar) 48 units subcutaneous daily.</p> <p>Review of subsequent physician's orders dated 03/21/16 for Resident #1 revealed: -If the blood sugar is greater than 400, give sliding scale insulin per MD instructions, recheck in 30 minutes and document. Then contact Resident Care Coordinator (RCC) or Administrator and/or call MD. -Increase Levimir to 50 units every hour of sleep.</p>	D 273		

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D 273	<p>Continued From page 40</p> <p>Review of Resident #1's FSBS log from March, 21 2016 thru April 20, 2016 revealed: -On 3/31/16 Resident #1's 8:00 p.m. FSBS was 406. There was no documentation the FSBS was rechecked and no was documented for MD notification. -On 04/15/16 at 8:00 p.m. the FSBS was 452. There was no documentation the FSBS was rechecked in 30 minutes and no was documented for MD notification.</p> <p>Review of subsequent physician's orders for Resident #1 dated 04/21/16 for hyperglycemia parameters revealed if blood sugar is above 300, check MAR for sliding scale and give appropriate dose of insulin ordered, recheck in 30 minutes, if symptoms worsen or blood sugar does not decrease, contact physician or call 911.</p> <p>Review of Resident #1's FSBS log from April 21, 2016 thru May 24, 2016 revealed: -The 6:00 a.m. FSBS was documented above 300 eight times ranging from 308 to 552. -There was documentation on 05/15/16 that a FSBS of 552 was rechecked 30 minutes later at 476, however, there was no documentation that the primary care provider was called. -There was no documentation the blood sugar was rechecked for the remaining seven FSBS above 300. -No was documented for MD notification for the remaining seven FSBS above 300 at 6:00 a.m. -The 8:00 p.m. FSBS was documented above 300 eighteen times ranging from 325-HI. -There was no documentation the FSBS were rechecked in 30 minutes for the eighteen FSBS above 300 at 8:00 p.m. -No was documented for MD notification for the eighteen FSBS above 300 at 8:00 p.m.</p>	D 273		

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D 273	<p>Continued From page 41</p> <p>Review of subsequent physician's orders for Resident #1 revealed:</p> <ul style="list-style-type: none"> -There was an order dated on 05/25/16 for hyperglycemic parameters as follows: normal range 80-130, call MD if blood sugar is greater than 400, recheck in 30 minutes and document then contact RCC or administrator and/or call MD. - There was an order dated 05/31/16 to start Novolin Insulin sliding scale due to increase in blood sugar twice daily. 200-250 = 3 units, 251-300 = 5 units, 301-350 = 7 units, 351-400 = 10 units, 401-450 = 12 units, call MD (primary care provider) if blood sugar is greater than 400. <p>Review of Resident #1's FSBS log from May 25, 2016 thru June 09, 2016 revealed:</p> <ul style="list-style-type: none"> -The 6:00 a.m. FSBS was documented above 400 eight times ranging from 403-HI. -There was no documentation that the blood sugar was rechecked in 30 minutes for the eight FSBS above 400 at 6:00 a.m. -There were 7 times no was documented for MD notification and one time there was no documentation for MD notification for the FSBS above 400 at 6:00 a.m. -The 8:00 p.m. FSBS was documented above 400 eleven times ranging from 415-HI. -There was no documentation that the blood sugar was rechecked in 30 minutes for the eleven FSBS above 400 at 8:00 p.m. -No was documented for MD notification for the eleven FSBS above 400 at 8:00 p.m. <p>Review of subsequent physician's orders for Resident #1 revealed:</p> <ul style="list-style-type: none"> -There was an order dated 06/10/16 normal range 80-130, call MD if blood sugar is greater than 450, recheck in 30 minutes and document then contact RCC or administrator and/or call 	D 273		

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D 273	<p>Continued From page 42</p> <p>MD.</p> <p>-There was an order dated on 06/24/16 for Levimir 10 units every morning.</p> <p>Review of Resident #1's FSBS log from June 10, 2016 thru June 30, 2016 revealed:</p> <p>-The 8:00 p.m. FSBS was documented above 450 five times ranging from 477-564.</p> <p>-There was no documentation that the blood sugar was rechecked in 30 minutes for the five FSBS above 450 at 8:00 p.m.</p> <p>-No was documented for MD notification for the five FSBS above 450 at 8:00 p.m.</p> <p>Resident #1 was not available for further interviews after 08/04/16 due to a discharge to another facility which was requested by the resident.</p> <p>Interview with a Medication Aide (MA) on 08/08/16 at 9:50 a.m. revealed:</p> <p>-She could not recall if she had notified the primary care provider when Resident #1's blood sugar was outside of the ordered parameter.</p> <p>-A MA would only call a primary care provider if the resident had ordered parameters even if it read HI.</p> <p>-Resident #1's blood sugars usually did not run high unless she had eaten something she was not supposed too.</p> <p>Interview with a second MA on 08/08/16 at 6:55 p.m. revealed:</p> <p>-It was expected for all MAs to follow the individual parameters ordered by the resident's physician and to call the physician when results were out of range.</p> <p>-It was the MA's responsibility to contact the physician when a resident's blood sugar was out of range.</p>	D 273		

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D 273	<p>Continued From page 43</p> <ul style="list-style-type: none"> -If the MA was unable to call the physician then the RCC could call during the week. -When a physician is called there should be documentation on the back of the MAR or in the record. -There had been staff meetings with the MA's recently concerning medication documentation. <p>Interview with a third MA on 08/09/16 at 5:30 p.m. revealed:</p> <ul style="list-style-type: none"> -The residents' blood pressure and FSBS parameters ordered by the physician were documented and kept on the medication cart. -She was unsure why there was no documentation when she had tested Resident #1's FSBS and it was out of parameters. -She felt if she did not document, the physician was not called. She may have called the physician once when the resident's blood sugar was high. -Resident #1 never showed any signs of high blood sugar such as "Shaky or dizzy" and "she would always act fine". <p>Interview with the Resident Care Coordinator on 08/05/16 at 11:15 a.m. revealed:</p> <ul style="list-style-type: none"> -The residents' parameters were documented and kept with the Medication Administration Record (MAR) on the medication carts. -It was expected that all parameters be followed as ordered by the primary care provider. -The lead MA did weekly random audits on the residents' records and had identified there were some issues with not calling the primary care provider when the blood sugars were too high or too low. -The lead MA and the RCC had reviewed ordered parameters and discussed the issue of no documentation in the residents' record in a group meeting and had met individually with the MA's. 	D 273		

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D 273	<p>Continued From page 44</p> <ul style="list-style-type: none"> -The lead MA also placed a note on the medication carts to remind the MA's to call the primary care providers when the ordered parameters were out of range. <p>Telephone interview with Resident #1's primary care provider on 08/08/16 at 9:10 a.m. revealed:</p> <ul style="list-style-type: none"> -The resident started on a sliding scale insulin due to the high blood sugar results in June 2016. -She recalled there were times the Medication Aides (MA) would call regarding the high blood sugars but could not recall if they had done so each time the results were out of parameter or high. -She expected to be notified at the time when the resident's blood sugars were elevated or high. -She felt the residents' recent blood sugars had been stable and had reviewed her blood sugar results on her visits to the facility. -The facility always provided her with documentation of the resident's blood sugar results when she went to make visits at the facility. <p>C. Review of Resident #1's current FL-2 dated 03/04/16 included an order to check blood pressures weekly.</p> <p>Review of a subsequent physician's orders revealed there was an order for blood pressure parameters on 03/21/16, if systolic blood pressure was greater than 160 or systolic is less than 90, or if diastolic is greater than 90 or less than 50, recheck in 15 minutes to ensure accuracy and then contact RCC or Administrator and or call physician if no change, document recheck on back of MAR.</p> <p>Review of Resident #1's documented weekly blood pressure results for March 2016 revealed a</p>	D 273		

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D 273	<p>Continued From page 45</p> <p>blood pressure on 03/09/16 of 142/99.</p> <p>Review of Resident #1's documented weekly blood pressure results for April 2016 revealed a blood pressure on 04/06/16 of 144/95.</p> <p>Review of Resident #1's documented weekly blood pressure results for May 2016 revealed one blood pressure on 05/04/16 of 169/94.</p> <p>Review of a subsequent physician's order dated 05/25/16 revealed blood pressure parameters, to call physician if systolic blood pressure is greater than 200 or less than 90, diastolic is greater than 90 or less than 50, recheck in 15 minutes to ensure accuracy and then contact RCD or Administrator and or call physician if no change, document recheck on back of MAR.</p> <p>Review of subsequent physician's orders revealed an order for blood pressure parameters revealed on 6/10/16 there was a signed order for blood pressure parameters to call physician if systolic blood pressure is greater than 180 and diastolic greater than 100, call physician if systolic pressure is less than 90 or diastolic less than 50, recheck in 15 minutes to ensure accuracy and then contact RCD or Administrator and or call physician if no change, document recheck on back of MAR.</p> <p>Review of Resident #1's documented weekly blood pressure results for July 2016 revealed one blood pressure on 06/06/16 of 89/62.</p> <p>Record review for Resident #1 revealed there were 4 times out of 20 opportunities there was no documentation that the primary care provider was contacted when the blood pressure results were documented outside of the ordered parameters.</p>	D 273		

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D 273	<p>Continued From page 46</p> <p>Review of Resident #1's documented weekly blood pressure results for August 2016 revealed a blood pressure on 08/03/16 of 118/81.</p> <p>Interview with a MA on 08/08/16 at 6:55 p.m. revealed: -It was expected for all MA's to follow the individual parameters ordered by the resident's physician and to call the physician when results were out of range. -It was the MA's responsibility to contact the physician when a blood pressure was out of range. -If the MA was unable to call the physician then the RCC could call during the week. -When a physician is called there should be documentation on the back of the MAR or in the record.</p> <p>Interview with a second MA on 08/09/16 at 5:30 p.m. revealed: -Documentation of the blood pressure parameters ordered by the physician were kept on the medication cart. -Resident #1 never showed any signs such as low or high blood pressure.</p> <p>Interview with the RCC on 08/05/16 at 11:15 a.m. revealed: -Documentation of the residents' parameters were kept with the MARs on the medication carts. -It was expected that all orders should be followed as ordered by the primary care provider. -The lead Medication Aide did weekly random audits on the resident charts and had identified there were some issues with not calling the primary care provider when the blood pressures were too high or too low.</p>	D 273		

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D 273	<p>Continued From page 47</p> <p>Interview with the primary care provider (PCP) on 08/08/16 at 9:10 a.m. revealed:</p> <ul style="list-style-type: none"> -The resident's blood pressure had been stable. She had reviewed the resident's blood pressure results on her visits to the facility. -The facility always provided documentation of the resident's blood pressure results when the PCP went to make visits at the facility. <hr/> <p>The facility submitted a Plan of Protection dated 8/09/16, as follows:</p> <ul style="list-style-type: none"> -Immediately, the Mediation Aides (MA) were trained on proper procedures for documenting resident's blood sugars and blood pressures and when to contact the resident's physician. -The MAs will also be trained by the Licensed Health Professional Support (LHPS) task nurse on proper documentation for blood sugars and blood pressures. -The resident transporter will keep a tracking log of the residents' appointments. -The Resident Care Coordinator (RCC), the lead MA and the head Supervisor-in-Charge from each shift will check behind each other daily to assure residents with high blood sugars and high blood pressures are contacted by the resident's physician. -The RCC and the lead MA will keep a copy of all resident appointments and assure resident appointments are kept daily. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 23, 2016</p>	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service	D 282		

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D 282	<p>Continued From page 48</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the reach-in cooler, the reach-in freezers, the food storage bins, and the dining room floor, wall and ceiling were cleaned.</p> <p>The findings are:</p> <p>Observation of the kitchen on 8/03/16 at 1:40 p.m. revealed: -There was built-up black grease on the side wall of the fryer. -The floor beside the fryer had greasy stains with black splattered circles. -The floors throughout the kitchen had scattered dirt and debris.</p> <p>Observation of a 3 compartment reach-in cooler on 08/03/16 at 1:43 p.m. revealed: - There was white scattered, dried stains inside the bottom shelf of the 1st compartment. - There was an area with brown and orange stains on the top portion of the back wall. - There was a cream and black colored substance inside the 1st and 2nd white coated racks of the 2nd compartment. - There were brown and orange spattered stains on the back wall of the 3rd compartment. -There was a brown and black substance on all 3 white coated racks in the 3rd compartment. -There was a white sticky substance and a wet green liquid on the bottom shelf of the 3rd compartment.</p>	D 282		

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D 282	<p>Continued From page 49</p> <ul style="list-style-type: none"> -There were splattered dried white stains on the outside walls of the reach in cooler. -There were areas of white and brown dried substance along the entire length of the vent cover. <p>Observation in the dining room on 08/03/16 at 3:58 p.m. revealed:</p> <ul style="list-style-type: none"> -There were multiple areas of old wax, which appeared to be peeling off leaving a black grey dull finish, scattered across the floor. -There was scattered dust, brown grime and debris along the baseboards. -There was dust, dirt and dead, dried insects along the window ledges of the dining room. -There was missing areas of cracked popcorn material scattered across the ceiling ranging in size from 2x2 inches long to 1x5 inches long. -A metal wall covering was applied over half of the walls in the dining room. One section had detached from the wall that left a corner protruding outward. There were tables and chairs in close proximity of the detached section. <p>Observation of the upright freezers and the pantry room on 08/03/16 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -There were dried brown and white splotches and smears scattered across the front of the 1st freezer. -There was scattered areas of orange and brown debris in the rubber sealant of the 1st freezer. -There were multiple areas of a cream and white dried substance along the entire vent cover of the 1st freezer. -There was a gritty sticky wet substance at the bottom of the inner freezer door of the 2nd freezer. -There were yellow and white stains and food crumbs on the vent cover of the 2nd freezer. -There were yellow, white and brown smears and 	D 282		

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D 282	<p>Continued From page 50</p> <p>stains along the metal portion of the outside door of the 2nd freezer.</p> <ul style="list-style-type: none"> -There was a chipped area, approximately the size of a quarter, on the inner, lower portion of the 3rd freezer exposing the inner yellow foam. -There were splotchy, red areas on the metal panel portion on the front of the door of the 3rd freezer. -There were dried, shiny splotches scattered across the pantry floor. -The light switch cover had brown stains of grime. <p>Observation of the large white food bins in the pantry on 08/03/16 at 2:25 p.m. revealed:</p> <ul style="list-style-type: none"> -Nineteen out of 33 bins had a loose gritty substance on the container lids. -Four out of 33 bins had a brown dried substance on the side. <p>Interview with a Cook on 08/03/16 at 4:15 p.m. revealed:</p> <ul style="list-style-type: none"> -There was a total of 3 dietary staff members, 2 full time and one part time. -Dietary staff swept and mopped the floors in the kitchen, pantry and dining room daily and as needed. -A dietary worker cleaned some of the baseboards in the dining room yesterday. -The dietary worker started cleaning some of the chrome appliances in the kitchen today. -There was no written check list or cleaning schedule for dietary. -They cleaned in areas that needed to be cleaned. <p>Interview with the Administrator on 08/03/16 at 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> -There was no dietary manager. -The dietary staff members were supervised by the Administrator and the Resident Care 	D 282		

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D 282	<p>Continued From page 51</p> <p>Coordinator (RCC).</p> <ul style="list-style-type: none"> -There was an expectation that cleaning should be done in the kitchen and dining room after each meal. -A dietary staff member performed the deep cleaning about 2 weeks ago. -The deep cleaning consisted of scrubbing the top of the stove, changing the grease in the fryer, and cleaning any other area that needed attention. -The Administrator was unsure when the walls in the kitchen were cleaned last. -The Administrator was unsure when the walls and racks were cleaned in the reach-in cooler and the freezers. -There was no designated schedule to clean the food bins in the pantry that she knew about. -The facility did not have a written cleaning schedule. -The expectation was for dietary to clean everything, including the reach-in cooler and freezers, as needed. -When the reach-in cooler and freezers were cleaned, the food should be taken out and the shelves and doors should be cleaned. -The Administrator monitored the dietary area this past Monday but did not look at the cleanliness in detail. -She was not aware the walls, reach in cooler, freezers and floors had not been cleaned. <p>Interview with a second Cook on 08/04/16 at 4:45 p.m. revealed:</p> <ul style="list-style-type: none"> -There was no cleaning schedule for the kitchen. -She and the other full time dietary staff member worked together to get the cleaning needs done. -The floors in the kitchen area and dining room were swept and mopped one to two times per day if there were two workers there; and if not, they only had time to spot mop. 	D 282		

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D 282	<p>Continued From page 52</p> <ul style="list-style-type: none"> -She had removed the racks in the reach-in cooler and cleaned them twice since February 2016. -She wiped down the racks in the reach-in cooler every day. -She removed the racks from the reach-in cooler today and cleaned them. -She could not give an exact date of the last time that the walls in the kitchen had been cleaned. <p>Interview with the second Cook on 08/05/16 at 12:50 p.m. revealed:</p> <ul style="list-style-type: none"> -She communicated over the phone with her coworker that worked full time concerning the cleaning needs since they worked on opposite days, -The other full time dietary aide did most of the deep cleaning. -She would deep clean in the areas that had been specified by the other full time dietary aide. -She did not clean the reach-in coolers nor the freezer; the other full time staff member did that. -The baseboards in the dining room were last cleaned 3 months ago. 	D 282		
D 283	<p>10A NCAC 13F .0904(a)(2) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure food was not exposed to cross contamination related to the foods storage,</p>	D 283		

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D 283	<p>Continued From page 53</p> <p>uncovered food and raw meats that were placed in unlabeled, plastic storage bags in the reach-in cooler and freezer and contamination from loose debris on the dry storage bin lids and no bin lid on one of the dry storage bins.</p> <p>The findings are:</p> <p>Observation of the reach-in cooler on 08/03/16 at 1:50 p.m. revealed:</p> <ul style="list-style-type: none"> -There was a storage bin that contained 4 raw sausage links in a closed, sealed, unlabeled plastic bag which was stored in the same bin and on top of approximately 22 single serve closed packets of sour cream and margarine/butter. -There was a wilted partial head of lettuce, wrapped in aluminum foil, partially uncovered, exposing one side of the lettuce. - There was a cream and black colored substance on the white, wired racks where the uncovered lettuce was stored. -There was one unwrapped pod of bell pepper stored in the bottom of an open top storage bin. The loose pod of pepper was beside an opened plastic bag containing 4 additional pods of bell pepper. -There was a 2nd closed, unlabeled plastic bag of raw meat stored in a open bin along with 2 closed packages of cooked deli meat on a bottom shelf. <p>Observation of the reach-in freezers on 08/03/16 at 2:11 p.m. revealed:</p> <ul style="list-style-type: none"> -There was frozen, cooked deli meat stored on the same top shelf as raw frozen meats, stored on top of each other with the deli meat beside and under the raw meats. -There was precooked packaged frozen meat stored on the 2nd shelf underneath the frozen raw meat on the 1st shelf. -There was a plastic bag containing frozen raw 	D 283		

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D 283	<p>Continued From page 54</p> <p>meat that was not labeled on the 1st shelf. -There was raw frozen meats stored on top of frozen cooked deli meat on the 3rd shelf.</p> <p>Observation of a large, white dry storage bin on 08/03/16 at 2:44 p.m. revealed the bin was ¼ full of loose dry pinto beans and had no lid cover.</p> <p>Interview with the Administrator on 08/03/16 at 4:30 p.m. revealed: -There was an expectation for dietary staff to follow all sanitation practices. -There was one dietary staff person certified in Servsafe. -She was not aware there were bags of meat with no labeling indicating dates opened and expiration dates. -All dry storage food bins should be clean and covered with a tight fitting lid. -Raw and cooked meats should not be stored one on top of the other. -Raw meat should not be stored on top of sour cream and butter. -She monitored the kitchen last Monday, and did not see any concerns, but did not look in detail.</p> <p>Observation of the reach-in cooler on 08/05/16 at 9:58 a.m. revealed: -There was one plastic bag containing raw bacon that was dated and initialed. -The cooked deli meats were stored on one bottom shelf and the raw meats were stored on a separate bottom shelf.</p> <p>Observation of the dry storage bins on 08/05/16 at 10:05 a.m. revealed the pinto beans were covered with a lid.</p> <p>Interview with a Cook on 08/05/16 at 12:50 p.m. revealed:</p>	D 283		

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D 283	Continued From page 55 -She was not certified in dietary training. -She was dependent on the other dietary staff cook to advise her of sanitation regulations. -She knew it was a requirement for any open packages of food to be labeled with the date opened, the date the food expired, and staff initials.	D 283		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure the residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to hot water temperatures and health care. The findings are: 1. Based on observations and interviews, the facility failed to assure the hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 6 of 15 fixtures. [Refer to Tag D113, 10A NCAC 13F .0311(d). (Type A2 Violation)] 2. Based on record review and interviews, the facility failed to notify the resident's primary	D912		

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D912	Continued From page 56 provider regarding elevated blood pressures, finger stick blood sugar results obtained outside of the established parameters and failed to ensure medical screening refusals were reported to the primary provider for 1 of 4 residents sampled (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b). (Type B Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the facility was not neglected related to the septic tank system and management of facilities. The findings are: 1. Based on observations and interviews, the facility failed to assure the facility's septic tank system had been maintained in a safe and operating condition resulting in sewage not properly flushing causing water to back-up in showers, commodes and the facility's washing machine. [Refer to Tag D105, 10A NCAC 13F .0311(a). (Type A2 Violation)] 2. Based on observations, interviews and record review, the Administrator failed to assure the total operations of the facility as evidenced by noncompliance related to physical environment, housekeeping and furnishings, other requirements, such as electrical, mechanical and plumbing equipment, hot water temperatures,	D914		

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D914	Continued From page 57 health care and cleanliness of the food storage areas. [Refer to Tag D176, 10A NCAC 13F .0601(a). (Type A2 Violation)]	D914		