

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL041023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/30/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ST GALES ESTATES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405</b>
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(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 Guilford County Department of Social Services conducted an annual survey and complaint investigation on August 23-25 and August 30, 2016.	D 000		
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 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 walls and floors were kept clean and in good repair in shared residents' rooms located throughout the facility.</p> <p>The findings are:</p> <p>A. Observation on 8/23/16 during the initial tour of the facility revealed:</p> <ul style="list-style-type: none"> <li>-The facility had three halls A, C, and E hall.</li> <li>-Two residents shared room E10.</li> <li>-Room E10 had a blackish gray build-up around the bottom of all the baseboards in the room and the top of the baseboards were brownish crusty with dirt build-up.</li> <li>-Behind both residents' beds were dead bed bugs too numerous to count on the floor and around the footing of the beds.</li> <li>-On one of the resident's bed a live bed bug was observed.</li> <li>-Room E10 had a blackish build up in the corners of the room and behind the entrance door with multiple dead bed bugs and spiders on the floor</li> </ul>	D 074		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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D 074	<p>Continued From page 1</p> <p>approximately 2 inches from the corner of the wall.</p> <ul style="list-style-type: none"> <li>-The threshold dividing the room and the bathroom was missing and a blackish substance was in the cracks of the flooring.</li> <li>-The walls behind both residents' beds were stained with what appeared to be dried blood.</li> </ul> <p>Interview on 8/23/16 at 10:35 am with one of the residents in room E10 revealed:</p> <ul style="list-style-type: none"> <li>-The room had always looked like that.</li> <li>-Housekeeping cleaned the room everyday, but they had not been in on 8/23/16 to clean the room.</li> <li>-He was unaware what the "bugs" on the floor were.</li> </ul> <p>Refer to interview on 8/23/16 at 10:00 am with housekeeping staff.</p> <p>Refer to observation on 8/25/16 between 10:00 am and 11:30 am of the housekeeping staff.</p> <p>Refer to interview 8/25/16 at 3:45 pm with the Administrator.</p> <p>B. Observation on 8/23/16 during the initial tour of the facility of room E12 revealed:</p> <ul style="list-style-type: none"> <li>-Two residents shared room E12.</li> <li>-One resident was in room E12 during the initial tour.</li> <li>-All the baseboards had a blackish substance around the edge of the baseboards and on the floors adjacent to the baseboards.</li> <li>-The corner of the rooms had a blackish dirt build-up with dead bed bugs in all the corners.</li> <li>-There were dead bed bugs too numerous to count on the floor behind the beds, and near the frame of the beds.</li> <li>-There were dead bed bugs on the floors behind</li> </ul>	D 074		

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D 074	<p>Continued From page 2</p> <p>both dressers in the room.</p> <p>-The walls behind both residents' beds were stained with what appeared to be dried blood.</p> <p>Interview on 8/23/16 at 11:00 am with one of the residents in room E12 revealed:</p> <p>-He had lived in the facility for about 10 years.</p> <p>-Housekeeping cleaned the room everyday.</p> <p>-He was aware the dead bugs were bed bugs.</p> <p>-He had complained to staff 3 months ago bed bugs were in his room.</p> <p>-The staff took out the mattress and bought new ones about 3 months ago.</p> <p>Refer to interview on 8/23/16 at 10:00 am with housekeeping staff.</p> <p>Refer to observation on 8/25/16 between 10:00 am and 11:30 am of the housekeeping staff.</p> <p>Refer to interview 8/25/16 at 3:45 pm with the Administrator.</p> <p>C. Observation on 8/23/16 between 10:30 am and 1:00 pm of room M12 located on the M hall revealed:</p> <p>-Two residents shared room M12.</p> <p>-The bed near the window had dead bed bugs on the floor behind and under the bed.</p> <p>-The corner of the rooms had a dirty black build-up with dead bed bugs to numerous to count in all the corners.</p> <p>-There were dead bed bugs on the floor near the frame of the beds.</p> <p>-There were dead bed bugs on the floors behind both dressers in the room.</p> <p>-The walls behind both residents' beds were stained with what appeared to be dried blood.</p> <p>Attempted interview on 8/23/16 at 12:15 pm with</p>	D 074		

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D 074	<p>Continued From page 3</p> <p>a resident in room M12 was unsuccessful.</p> <p>Refer to interview on 8/23/16 at 10:00 am with housekeeping staff.</p> <p>Refer to observation on 8/25/16 between 10:00 am and 11:30 am of the housekeeping staff.</p> <p>Refer to interview 8/25/16 at 3:45 pm with the Administrator.</p> <p>D. Observation on 8/23/16 between 10:30 am and 1:00 pm of room M7 located on the M hall revealed:</p> <ul style="list-style-type: none"> <li>-Two residents shared room M7.</li> <li>-The corners of the room had a dirty black build-up on the baseboards with dead bed bugs on the floor.</li> <li>-There were dead bed bugs on the floor behind the beds and under the bed.</li> <li>-There were dead bed bugs on the floor near the frame of the beds.</li> <li>-There were dead bed bugs on the floors behind both dressers in the room.</li> </ul> <p>Interview on 8/23/16 at 12:25 pm with both residents in room M7 revealed:</p> <ul style="list-style-type: none"> <li>-They were aware the dead bugs on the floor were bed bugs.</li> <li>-One residents said she told staff bedbugs were biting her at night.</li> <li>-Housekeeping had cleaned the room already on 8/23/16.</li> </ul> <p>Refer to interview on 8/23/16 at 10:00 am with housekeeping staff.</p> <p>Refer to observation on 8/25/16 between 10:00 am and 11:30 am of the housekeeping staff.</p>	D 074		

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D 074	<p>Continued From page 4</p> <p>Refer to interview 8/25/16 at 3:45 pm with the Administrator.</p> <p>E. Observation on 8/23/16 between 10:30 am and 1:00 pm of room M4 located on the M hall revealed:</p> <ul style="list-style-type: none"> <li>-Two residents shared room M4.</li> <li>-The corners of the room had a dirty black build-up with dead bed bugs on the floor.</li> <li>-All the baseboards had a blackish substance around the top edge of the baseboards and on the floors directly beneath the baseboards.</li> <li>-There were dead bedbugs to numerous to count on the floor behind the beds and under the bed.</li> <li>-There were dead bedbugs on the floor near the frame of the beds.</li> <li>-There were dead bedbugs on the floors behind both dressers in the room.</li> </ul> <p>Refer to interview on 8/23/16 at 10:00 am with housekeeping staff.</p> <p>Refer to observation on 8/25/16 between 10:00 am and 11:30 am of the housekeeping staff.</p> <p>Refer to interview 8/25/16 at 3:45 pm with the Administrator.</p> <p>F. Observation on 8/23/16 between 1:00 pm and 2:00 pm of 4 rooms (A5, A6, A7, and A9) located on the A hall revealed:</p> <ul style="list-style-type: none"> <li>-All rooms were shared residents' rooms.</li> <li>-In all the corners of the rooms there was a blackish substance build-up around the edge of the baseboards with dead bed bugs and other bugs in the corners.</li> <li>-Dead bed bugs to numerous to count were around all the baseboards.</li> <li>-There were dead bed bugs on the floor behind the bed frames and under the beds.</li> </ul>	D 074		

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D 074	<p>Continued From page 5</p> <p>-There were dead bed bugs located on the floor near the frames of the beds.</p> <p>-There were dead bed bugs on the floors behind all the dressers in the room.</p> <p>Refer to interview on 8/23/16 at 10:00 am with housekeeping staff.</p> <p>Refer to observation on 8/25/16 between 10:00 am and 11:30 am of the housekeeping staff.</p> <p>Refer to interview 8/25/16 at 3:45 pm with the Administrator.</p> <p>_____</p> <p>Interview on 8/23/16 at 10:00 am with the housekeeping staff revealed:</p> <p>-Housekeeping staff worked day shift, 3 to 5 days weekly.</p> <p>-Housekeeping staff were responsible for cleaning the residents' rooms, common areas and common bathroom.</p> <p>-They swept, mopped and dusted, each residents' room daily.</p> <p>-They were not responsible for changing residents' linens or laundry.</p> <p>-They were not aware bed bugs were in the facility.</p> <p>-They were not aware dead bed bugs were in residents' rooms on floors and under furniture.</p> <p>Observation on 8/25/16 between 10:00 am and 11:30 am of the housekeeping staff revealed:</p> <p>-Housekeeping staff were mopping the residents' rooms on the A Hall.</p> <p>-Each time they completed mopping a resident room, they used the same mop water.</p> <p>Interview 8/25/16 at 3:45 pm with the Administrator revealed:</p>	D 074		

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D 074	Continued From page 6  -She was unaware residents' rooms located on all three halls had areas of blackish substance on the baseboards and floors. -She was unaware there were dead bed bugs located in residents' rooms located on all the halls in the facility. -She relied on housekeeping to clean the residents' rooms and the common areas. -No resident had complained to her about the floors and walls being dirty or the dead bed bugs on the floors.	D 074		
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; 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 assure the furniture in residents' rooms was kept clean and in good repair.  The findings are:  Observation of resident room #A1 on 08/23/16 at 9:35 am revealed: -The handles were missing from the top drawer of the dresser. -The handles were missing from the top drawer of the night table.  Observation of resident room #A2 on 08/23/16 at 9:38 am revealed the handles missing from the dresser.	D 076		

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D 076	<p>Continued From page 7</p> <p>Observation of resident room #A4 on 08/23/16 at 9:50 am revealed: -The handles were missing from the top drawer of the dresser. -The dresser had multiple deep scratches on both sides. -The night table was missing handles from both top and bottom drawer.</p> <p>Observation of resident room #A5 on 08/23/16 at 9:55 am revealed: -The night table was missing handles from both top and bottom drawers. -The handles were missing from the top drawers of the dresser.</p> <p>Observation of resident room #M7 on 08/24/16 at 11:35 am revealed: -There were 2 dressers in the room. -Both dressers had multiple, deep scratches. -Both dressers were missing a handle from the top drawer.</p> <p>Observation of resident room #M12 on 08/24/16 11:40 am revealed: -The top drawer of the dresser was missing a handle. -The bottom drawer of the dresser was missing a handle.</p> <p>Observation of resident room #M10 on 08/24/16 at 11:45 am revealed: -The surface of the night table was scratched. -The dresser was also deeply scratched.</p> <p>Observation of resident room #E5 on 08/24/16 at 11:50 am revealed: -2 dressers were in the room. -Both dressers were missing handles from the top</p>	D 076		

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D 076	<p>Continued From page 8</p> <p>drawer.</p> <p>-The handle for the top drawer of the night table was broken.</p> <p>Observation of resident room #E5 on 08/24/16 at 11:55 am revealed:</p> <p>-2 dressers were in the room.</p> <p>-There were no handles at all on the top drawer of one of the dressers.</p> <p>-The other dresser was scratched and was missing a handle from the top drawer.</p> <p>Observation of resident room #E9 on 08/24/16 at 12:00 pm revealed:</p> <p>-2 dressers were in the room.</p> <p>-Both dressers were missing handles for the top drawers and both were deeply scratched.</p> <p>-The drawer of the night table had no handles and was scratched.</p> <p>Confidential interview with a resident revealed:</p> <p>-He didn't know how long the handles had been missing from the night table and dresser in his room.</p> <p>-It was harder to open the drawers without the handles.</p> <p>-He hadn't told anyone about the missing handles, because "anybody could see that they are missing".</p> <p>Confidential interview with a second resident:</p> <p>-The handles had been missing from the dresser in his room "for a while".</p> <p>-He did not remember if he had told any of the staff about the missing handles.</p> <p>Confidential interview with a staff member revealed:</p> <p>-Approximately 10 residents had complained about the missing handles on the dressers and</p>	D 076		

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D 076	<p>Continued From page 9</p> <p>night stand in the past year.</p> <ul style="list-style-type: none"> <li>-No one had repaired the missing handles.</li> <li>-No staff at the facility performed a regularly scheduled walk through of the building to assess for damages or items that might need repair.</li> <li>-Staff had reported the missing handles to the Assistant Administrator (AA).</li> <li>-Family members had complained about the missing handles also.</li> <li>-The facility did not have a maintenance employee at this time.</li> </ul> <p>Interview on 08/30/16 at 9:35 am with the AA revealed:</p> <ul style="list-style-type: none"> <li>-"A couple of residents" had complained about the missing handles on the night tables and dressers located in resident rooms.</li> <li>-Housekeeping staff would usually tell the BOM if anything needed to be repaired, and the AA would send a work order to the corporate office, and an employee would be sent out to make the repairs.</li> <li>-She had sent a work order to the corporate office "about a week and a half ago" requesting the handles be replaced.</li> <li>-The corporate office would send an employee out to fix the handles "soon".</li> <li>-Some of the handles had already been replaced and others still needed to be replaced.</li> <li>-The AA conducted a regularly scheduled assessment of the maintenance needs of the building by performing a walk through of the building daily.</li> </ul> <p>Interview on 08/30/16 at 10:45 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-None of the residents had complained about the missing handles on the night tables and dressers located in resident rooms.</li> <li>-Housekeeping staff reported any maintenance needs to the AA.</li> </ul>	D 076		

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D 076	Continued From page 10  -No one conducted a regularly scheduled walk through of the building to assess for maintenance needs. -None of the staff had reported any missing handles. -One family member had complained about the missing handles, and the handles have already been replaced in that resident's room.	D 076		
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: TYPE B VIOLATION  Based on observations, interviews, and record reviews the facility failed to maintain the facility in a clean and orderly manner free of obstructions and hazards in regards to bed bug infestation throughout the facility.  The findings are:  Observation on 8/23/16 between 9:30 am and 12:00 pm during the initial tour of the facility revealed: -The facility had three halls A, C, and E hall. -Two residents shared each room.	D 079		

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D 079	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-Multiple residents' sheets had dead bed bugs, casings (skin sheds), feces, and blood spots on the sheets and pillow cases.</li> <li>-Multiple resident's rooms had blackish gray build-up around the bottom of the baseboards and dead bugs seen throughout the facility on the floors in the rooms.</li> <li>-In multiple rooms behind residents' beds were dead bed bugs and casings on the floor and around the footing of the beds.</li> <li>-Several residents' rooms had blackish build up on the floors in the corners of the room and behind the entrance doors with dead bed bugs and casings on the floors.</li> <li>-Multiple residents' rooms had what appeared to be dried blood on the walls behind residents' beds.</li> </ul> <p>Interview on 8/23/16 at 10:00 am with the housekeeping staff revealed:</p> <ul style="list-style-type: none"> <li>-They were responsible for cleaning the residents' rooms, common areas and common bathroom.</li> <li>-The housekeeping staff swept, mopped and dusted, each resident's room daily.</li> <li>-They were not aware bed bugs were in the facility.</li> </ul> <p>Observation on 8/23/16 between 10:00 am and 11:00 am of two residents' rooms located on the E hall revealed:</p> <ul style="list-style-type: none"> <li>-The beds had a pillow in a pillow case, a top sheet, a bottom fitted sheet and bed spread.</li> <li>-Between the top sheet and the fitted bottom sheet there were dead bed bugs, casings, feces, and dark blood smears.</li> <li>-On the pillow cases there were blood spots, dead bed bugs, and casings.</li> <li>-In the corner of the fitted bottom sheets, there were feces and live bed bugs.</li> </ul>	D 079		

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NAME OF PROVIDER OR SUPPLIER  <b>ST GALES ESTATES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405</b>
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D 079	<p>Continued From page 12</p> <p>Confidential interview between 9:30 am and 10:30 am with several residents located down the E hall revealed:</p> <ul style="list-style-type: none"> <li>-They were aware bed bugs were in the rooms and in the facility.</li> <li>-They complained to the Medication Aides (MA) and Personal Care Aides (PCA) about 3 months ago.</li> <li>-They had been bitten on multiple occasions at night.</li> <li>-They have seen bed bugs and "smashed one and blood came out of it."</li> <li>-They had told their families the facility had bed bugs.</li> <li>-One resident was bringing the bed bugs into the facility, "He is gone everyday to a day program."</li> <li>-Management treated two rooms on the E hall about 3 months ago and had thrown the mattresses out and purchased new ones.</li> <li>-During this treatment, a pest control company came and sprayed the room.</li> <li>-The staff applied a plastic mattress cover to the mattresses after purchasing the new mattresses.</li> <li>-The wood dressers were not thrown away nor any of the furniture which included cloth chairs.</li> <li>-Housekeeping cleaned the rooms everyday which include sweeping, mopping and dusting.</li> </ul> <p>Confidential interview between 10:00 am and 11:45 am with several residents located down the M hall revealed:</p> <ul style="list-style-type: none"> <li>-They were aware bed bugs were in the residents' rooms and in the facility.</li> <li>-They complained to the Medication Aides (MA) and Personal Care Aides (PCA).</li> <li>-They had been bitten on the back and arm on multiple occasions at night.</li> <li>-Staff were aware of the bites and the doctor had ordered a cream for the bites and itching.</li> <li>-Some rooms were treated by the maintenance</li> </ul>	D 079		

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D 079	<p>Continued From page 13</p> <p>man who sprayed the rooms on several occasions. -They thought the common areas in the facility where the residents' sit had bed bugs too.</p> <p>Confidential interview between 10:00 am and 11:45 am with several residents located down the A hall revealed: -They were aware bed bugs were in the residents' rooms and in the facility. -Management was aware of the bed bugs and had been for several years. -For 2 years the bed bugs had been in the facility and in the residents' rooms. -They had been bitten on several occasions and had informed the MAs and the PCAs. -"I feel sorry for the residents who can not communicate with the staff to let them know if they are getting bitten by the bed bugs." -They had told their families the facility had bed bugs and they were getting bitten at night. -The facility had a maintance man spray the residents' rooms, but the pest control company had never sprayed the A hall.</p> <p>Observation on 8/23/16 at 10:40 am of resident rooms E10 and and E12 with the Administrator revealed bed bugs were in both rooms on the floors, bed linens, and behind the furniture.</p> <p>Interview on 8/23/16 at 10:40 am and 2:10 pm with the Administrator revealed: -She was unaware residents' rooms or the facility had bed bugs. -She would immediatley contact the professional pest control company on 8/23/16 to treat the facility for bedbugs as soon as possible. -The first time the facility had bed bugs was June 2016. -A professional pest control company treated the</p>	D 079		

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D 079	<p>Continued From page 14</p> <p>whole building at that time with a "bed bug solution."</p> <ul style="list-style-type: none"> <li>-One resident had gone to the Salvation Army and gotten clothing, " I bet that's where they came from."</li> <li>-All the residents' beds have plastic covers on the mattresses and box springs.</li> <li>-One staff person complained of bed bug bites in June 2016 and that's why I called the pest control company.</li> <li>-No bed bug education or training had been provided to the staff or residents.</li> <li>-No residents had been treated for bed bug bites.</li> <li>-The only recommendation the professional pest control company had was to purchase mattress covers for all the residents' beds.</li> <li>-Bed linens were changed weekly for all the residents.</li> </ul> <p>Confidential interviews with facility staff revealed:</p> <ul style="list-style-type: none"> <li>-They were aware the facility had bed bugs, and it had been going on for about 2 years.</li> <li>-The bed bugs had been seen in every room and in the common areas.</li> <li>-Residents had complained they had been bitten on several occasions.</li> <li>-They did inform the Medication Aides (MA), Resident Care Coordinator (RCC), Assistant Administrator (AA), and the Administrator when residents complained of bed bug bites.</li> <li>-They would slip notes under the door of the Administrator if she was not working or if it was the weekend.</li> <li>-Maintenance would spray the rooms for bed bugs, but he left the facility about 2 months ago.</li> <li>-"We use the maintenance man from the other facility, "He sprayed for bedbugs now."</li> <li>-"The bed bugs keep coming back."</li> <li>-Staff had been bitten on several occasion.</li> <li>-Staff had bed bugs in their home, they were not</li> </ul>	D 079		

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D 079	<p>Continued From page 15</p> <p>sure if the bed bugs came from the facility. -Family members had complained to them the residents were getting bitten at night. -Family members had spoken to the AA and the Administrator concerning the bed bugs in the facility. -Staff never sat in the chairs in the common area due to bed bugs in the furniture. -Staff had no education or training on bed bugs. -Management refused to pay for a commercial pest control treatment to treat the entire facility.</p> <p>Observation on 8/24/16 between 9:45 am and 11:00 am a professional pest control company was in the facility.</p> <p>Interview on 8/24/16 at 9:40 am with the local pest control company revealed: -The facility Administrator had contacted the office to treat the bed bugs in resident rooms E 10 and E12. -He had been treating bed bugs in the facility for 2 years. -He had treated room E7 and E9 for bed bugs the other time he was in the facility, about 3 months ago. -He had treated rooms E10 and E12 for bed bugs about a year ago. -He had never treated any other area or halls in the facility. -Staff and residents informed him the facility staff were spraying for bed bugs. -His recommendation to the Adminstrator was to treat the whole facility about 6 months ago. -He recommended to the Administrator about 6 months ago to allow the dogs in for a inspection of the facility and to identify the rooms bed bugs were located in. -He recommended treatment of all rooms across the halls and around the rooms he was currently</p>	D 079		

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D 079	<p>Continued From page 16</p> <p>treating on 8/24/16.</p> <ul style="list-style-type: none"> <li>-He recommended education of bed bugs for staff.</li> <li>-Each time the Administrator stated " She would think about it."</li> <li>-Staff and residents had complained to him about bed bugs in the facility each time he came in.</li> </ul> <p>Review of the local pest control company service agreement revealed:</p> <ul style="list-style-type: none"> <li>-On 7/30/16 the pest control company had treated 1 room with a spray chemical for bed bugs.</li> <li>-On 8/11/15 the pest control company had treated 3 rooms with a spray chemical for bed bugs.</li> <li>-On 9/25/15 the pest control company treated 1 room with a spray chemical for bed bugs.</li> <li>-On 3/8/16 the pest control company treated 1 room with a spray chemical for bed bugs.</li> <li>-Each time the pest control company came to the facility to treat for bed bugs they also completed a follow-up inspection in 14 days after the initial treatment.</li> <li>-No room numbers were identified in the service agreement as being treated for bed bugs.</li> </ul> <p>Confidential interview with a family member revealed:</p> <ul style="list-style-type: none"> <li>-She visited at the facility several times monthly.</li> <li>-She was aware bed bugs were in the facility, and had been in the facility for about a year.</li> <li>-She was told by the resident there were bed bugs in their room.</li> <li>-She was told by the resident the bed bugs were biting him at night.</li> <li>-She told the Assistant Administrator and the Admnistrator the resident had been bitten by bed bugs in his room.</li> <li>-To her knowledge in the past year this was the third time the pest control company had been out to treat the bed bugs in the facility.</li> </ul>	D 079		

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D 079	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-The Administrator had staff remove the old mattress and bought a new mattress with a plastic mattress cover about 6 months ago.</li> <li>-The maintenance man sprayed the room and staff washed the resident's clothes, but not sure if all the resident's clothes in the closet were laundered.</li> <li>-She informed the resident not to sit in the chairs in the common area, "I think the bed bugs are in the common area chairs."</li> <li>-Last week the resident complained to the family again of bed bugs bites.</li> <li>-"The bed bugs keep coming back."</li> </ul> <p>Observation on 08/23/16 at 3:15 pm of resident room E11 revealed:</p> <ul style="list-style-type: none"> <li>-There were blood spots on the wall near bed #2 by the door.</li> <li>-There was a white liquid substance on the wooden headboard of bed #1, by the door.</li> <li>-Bed #2 had bed bug casings on the floor at the head of the bed.</li> <li>-Bed #1 had bed bug casings on the box spring covers.</li> <li>-Bed bug casings were on the floor by the wall.</li> <li>-Cluster of bed bugs and casing were at the head of the bed.</li> </ul> <p>Observation on 08/23/16 at 3:40 pm of resident room E12 revealed:</p> <ul style="list-style-type: none"> <li>-There were two beds in the room, and both beds had a wooden headboard.</li> <li>-There was a liquid white substance that was dried on both headboards.</li> <li>-Bed #1 by the window had bed bugs casings all over the bed covers.</li> <li>-Bed #2 had dead bed bugs on the floor near the bed.</li> <li>-Dead bed bugs were observed on the floor by the night stand.</li> </ul>	D 079		

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D 079	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>-There was a blood smear was on the wall by the night stand, near bed #2.</li> <li>-There were dead bed bugs and ants in the corner of wall behind the door.</li> </ul> <p>Observation on 08/23/16 at 3:56 pm of resident room M6 revealed:</p> <ul style="list-style-type: none"> <li>-Bed #2 by the door had blood smears on the sheet under the pillow.</li> </ul> <p>Observation on 08/23/16 at 4:55 pm of Resident #13's revealed:</p> <ul style="list-style-type: none"> <li>-She had several small spots on her right and left arm, and on her right and left leg that were brown in color.</li> <li>-The resident identified the spots as bed bug bites.</li> <li>-Dead bed bugs were observed in the resident's room and casings near the wall on both sides of the room.</li> </ul> <p>Interview on 08/23/16 at 4:57 pm with Resident #13</p> <ul style="list-style-type: none"> <li>-She got bitten by the bed bugs two nights ago.</li> <li>-She told the Medication Aide on the third shift, the first shift MA/supervisor and the RCC.</li> <li>-The MA/supervisor put alcohol on her arm.</li> </ul> <p>Confidential interviews with three residents revealed:</p> <ul style="list-style-type: none"> <li>-One resident said there were bed bugs in the chairs in the piano room, which was a common sitting area for residents.</li> <li>-There were bed bugs in the chairs in the hallway.</li> <li>-A second resident said she had bed bugs in her room on a book shelf.</li> <li>-She had never gotten bit by the bed bugs, but she saw them crawl.</li> <li>-She got rid of the book shelf and had not seen any more bed bugs.</li> </ul>	D 079		

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D 079	<p>Continued From page 19</p> <p>-A third resident said yesterday a male resident in the room next to his room told him that he got bit by bed bugs on his legs. -He saw the spots on the male resident leg. -The male resident told him he had blood spots on his sheets.</p> <p>Interview on 08/25/16 at 8:30 am with Resident #7 revealed: -She had gotten bit on the leg by bed bugs on Tuesday (08/24/16), this was the second time she had gotten bit. -She told the first shift Medication Aide/supervisor, her roommate, and the third shift Medication Aide, and nothing was done.</p> <p>Second interview on 08/30/16 at 10:45 am with Resident #7 revealed: -She had bed bugs in her room, and was always bitten by the bugs. -Currently, she had bed bug bites on her right leg and right arm, which happened Friday night (08/26/16). -She told the Assistant Administrator, but she did nothing.</p> <p>Observation on 08/30/16 at 10:45 am of the Resident #7's right leg and arm revealed: -Multiple circular spots on the resident's arm and leg. -The spots were discolored darker than the rest of her body.</p> <p>Interview on 08/29/16 at 8:35 am with Resident #7's guardian revealed: -She came to the facility on Saturday to pick up Resident #7. -Resident #7 told her that she had bites all over her right arm and leg. -Resident #7 said the bites itched, so she went to</p>	D 079		

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D 079	<p>Continued From page 20</p> <p>the local drug store and purchased a cream to help with the itching. -She was unaware of the bite marks when at the facility. -When she returned Resident #7 to the facility on Sunday (08/28/16), she told the Assistant Administrator and the Resident Care Coordinator about the bite marks all over Resident #7's right arm and leg. -She was very upset about the bites and was told to call the Administrator.</p> <p>Confidential interview with a staff revealed: -She was directed not to tell the Nurse Practitioner (NP) about the "bed bugs bites." -She was told by the Administrator when asking for cream for the bites to tell the NP the resident was itching or had skin irritation. -She had observed bed bug bites on Resident #7, and she had observed live bed bugs all over Resident #7's bed on Sunday. -The NP was not contacted regarding the bites on Resident #7's body.</p> <p>Interview on 08/23/16 at 2:30 pm with the Administrator revealed: -A few months ago one staff did come to her and tell about the bed bugs, but that staff no longer worked at the facility. -In June 2016, a pest control company sprayed the whole room when bed bugs were identified. -When residents came to the facility she took their cloths and put them in the dryer. -She was not sure where bed bugs were coming from. -A few months ago she took precautions and bought 46 bed bug covers. -Most of the covers had been put on residents beds.</p>	D 079		

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D 079	<p>Continued From page 21</p> <p>Confidential interview with two staff revealed:</p> <ul style="list-style-type: none"> <li>-Bed bugs were in the lounge and piano room, which were the common sitting areas for residents, and in resident rooms.</li> <li>-A resident in room M10 had been getting cream for months due to bed bug bites.</li> <li>-Resident #13's, in room A5, neck was swollen and was "tore-up" from bed bug bites.</li> <li>-Resident #7 in room A5, had bed bugs bites on her yesterday, 08/22/16.</li> <li>-Staff put cream on the bites.</li> <li>-The cream came from the NP, but staff did not tell the NP they requested the cream for bed bug bites.</li> <li>-Staff was instructed by the Administrator to get the cream for itching, but not to tell the itching was caused by bed bug bites.</li> <li>-Staff were instructed to tell the NP the cream was dry skin itching and irritation.</li> <li>-Staff had been instructed if they see bed bugs to tell RCC or Administrator so they could spray.</li> <li>-Yesterday, she told the RCC about Resident #7 and #13 getting bit by bed bugs.</li> <li>-Staff on the third shift were afraid to sit down on the furniture for fear of taking the bed bugs home with them.</li> <li>-It was hard for staff to stand the entire third shift, so they cover the furniture with a sheet to ensure no bed bugs get on them.</li> <li>-Someone was coming out to spray (not sure how often), but it was not working.</li> </ul> <p>_____</p> <p>A Plan of Protection was provided by the facility on August 23, 2016 as follows:</p> <ul style="list-style-type: none"> <li>-The Administrator had staff remove all linens and clothing from E10 and E12, washed and dried several times on high heat.</li> <li>-The Administrator will contact the pest control company immediately to treat the bed bugs.</li> <li>-The residents' rooms will be checked and</li> </ul>	D 079		

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D 079	<p>Continued From page 22</p> <p>monitored for bed bugs for the next few weeks by the RCC and the MAs.</p> <p>-The Administrator will create a tracking form for the RCC to use when monitoring residents' rooms weekly for bed bugs until in compliance.</p> <p>-On 8/25/16 the POP was amended; Prior to admitting new residents to the facility, the Administrator will inform the families and residents the facility is being treated for bed bugs, this will continue until the bed bugs were completely gone from the facility and pest control clears the facility.</p> <p>-There will be no new admissions to the facility until the pest control company inspects, treats, and gives the recommendation the bed bugs are out of the facility.</p> <p>-Administrator will set up inservice for staff with local pest control company to educate on bed bugs sights.</p> <p>-On 8/30/16 the POP was amended; The pest control company will complete heat treatment for the entire facility to kill the bed bugs as soon as possible.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, October 15, 2016.</p>	D 079		
D 139	<p>10A NCAC 13F .0407(a)(7) Other Staff Qualifications</p> <p>10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40;</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure a Criminal Background</p>	D 139		

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D 139	<p>Continued From page 23</p> <p>check was completed prior to hire on 1 of 7 sampled staff (Staff B).</p> <p>The findings are:</p> <p>Review of Staff B's personnel records revealed:</p> <ul style="list-style-type: none"> <li>-Staff B was hired on 10/15/15 as a Personal Care Aide (PCA).</li> <li>-No documentation a criminal background check was completed for Staff B.</li> <li>-Staff B's responsibilities included providing personal care to residents.</li> </ul> <p>Interview on 8/23/16 at 10:00 am with Staff B revealed her duties included personal care to residents, bathing, feeding, transfers, and dressing.</p> <p>Observation on 8/23/16 between 10:30 am and 12:45 pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff B assisted a resident to the room for personal care.</li> <li>-Staff B assisted a resident with transfer to the common area via wheel chair.</li> <li>-Staff B assisted residents to the dining room via wheel chair and walkers.</li> </ul> <p>Interview on 8/25/16 at 9:45 am with the Assistant Administrator (AA) revealed:</p> <ul style="list-style-type: none"> <li>-She and the Administrator were responsible for completing criminal background checks for new staff.</li> <li>-She was aware criminal background checks were to be completed on all staff prior to hire.</li> <li>-She had not completed a criminal background on Staff B.</li> </ul> <p>Interview on 8/25/16 at 10:15 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-She and the AA were responsible for completing</li> </ul>	D 139		

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D 139	Continued From page 24  criminal background checks on all new staff. -She was aware criminal background checks were to be completed on all staff prior to hire. -She was not aware a criminal background check for Staff B was not completed. -She would complete a criminal background check on 8/25/16 for Staff B.	D 139		
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 observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs of 3 of 5 (Residents #1, and #2) regarding the need for continuous positive airway pressure (CPAP) therapy, Thrombo-Embolic Deterrent (TED) hose, and low blood pressures (BP).  The findings are:  A. Review of Resident #2's current hospital discharge FL2 dated 02/15/16 revealed: -Diagnoses included dementia, dyslipidemia, coronary arterial disease and sleep apnea. -An admission date of 06/20/14.  Additional review of Resident #2's record revealed: -A signed physician's order dated 04/04/16 for	D 273		

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D 273	<p>Continued From page 25</p> <p>"CPAP machine 2/Lpm at Bedtime". -A signed physician's order dated 07/26/16 for "CPAP machine 2/Lpm at Bedtime".</p> <p>Observation on 08/23/16 at 10:25 am revealed a CPAP machine on the floor beside Resident #2's bed, the CPAP machine was not in operation.</p> <p>Interview on 08/23/16 at 10:25 am with Resident #2 revealed: -The CPAP machine had been broken for about 4 months. -She had told the facility staff about it, but no one had done anything about the machine being broken. -She did not recall which staff she had told about the machine.</p> <p>Interview on 08/23/16 at 4:00 pm with a representative from the Durable Medical Equipment (DME) company that supplied Resident #2's CPAP machine revealed: -No one from the facility had called the DME company to notify them that the CPAP machine was not working. -No one had called to order CPAP machine supplies since 2013. -No one had called to order a new CPAP machine.</p> <p>Observation on 08/23/16 at 5:50 pm with a staff member revealed: -Resident #2's CPAP machine did not power up when turned on. -The staff member tried the electrical plug in a different outlet and it still did not power up. -The CPAP machine was taken to the nurses' station at that time. -The staff member called the DME provider and requested a replacement CPAP.</p>	D 273		

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D 273	<p>Continued From page 26</p> <p>Interview on 08/24/16 at 8:30 am with a representative from the prescribing practitioner's office revealed:</p> <ul style="list-style-type: none"> <li>-The prescribing practitioner was out on medical leave and the person on the phone had assumed the responsibility of the residents.</li> <li>-The last office visit on record for Resident #2 was "earlier in August 2016".</li> <li>-There was no documentation of the CPAP needing repair or that Resident #2 was having any difficulty with it.</li> <li>-The provider had not been informed the CPAP was not working.</li> <li>-There was a current order for "CPAP machine 2/Lpm at Bedtime".</li> </ul> <p>Interview on 08/23/16 at 5:45 pm with a Medication Aide (MA) who worked second shift revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had used the CPAP machine "for years".</li> <li>-Resident #2 had not reported a problem with the CPAP machine.</li> <li>-Resident #2 put on and took off the CPAP mask herself every night.</li> <li>-Staff just made sure she had it on every night.</li> <li>-The CPAP came apart one time and the staff put it back together with no problem.</li> </ul> <p>Interview on 08/24/16 at 7:40 am with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had used the same CPAP machine since she had moved into the facility.</li> <li>-Resident #2 had not needed any new supplies for the CPAP machine.</li> <li>-Staff made sure Resident #2 wore the mask every night, the resident put the mask on and took the mask off herself.</li> <li>-Resident #2 had not told anyone that the CPAP</li> </ul>	D 273		

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D 273	<p>Continued From page 27</p> <p>machine was broken.</p> <p>Second interview on 08/24/16 at 9:50 am with Resident #2 revealed: -A second shift MA usually filled the water portal in the machine. -When the CPAP machine is "broke, I can't breathe". -"I told the doctor, but she didn't do nothin' " about the CPAP machine. -"My breathing is worse since it's broken".</p> <p>Observation on 08/24/16 at 9:50 am of Resident #2 revealed no difficulty breathing or shortness of breath.</p> <p>Interview on 08/24/16 at 10:00 am with the second shift MA revealed: -Resident #2's CPAP had been broken "about a week" -Resident #2 had not been observed having difficulty sleeping or difficulty breathing.</p> <p>Interview on 08/24/16 with 2 members of Resident #2's family revealed: -Resident #2 had used the CPAP machine 4 or 5 years. -Resident #2 had not said anything about the machine not working. -They were not aware the CPAP machine was not working. -No one from the facility had reported the CPAP machine not working. -They had not noticed Resident #2 being sleepy or having any difficulty breathing.</p> <p>Confidential interview with a 3rd shift staff member revealed: -Resident #2 had the CPAP machine "for years". -Resident #2 did not use the CPAP machine.</p>	D 273		

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D 273	<p>Continued From page 28</p> <p>-She had never seen the CPAP machine in use.</p> <p>Confidential interview with another 3rd shift staff member revealed: -Resident #2 told her it was broken and the staff member reported it to the RCC, at least a year ago. -The CPAP machine had not worked since.</p> <p>Interview on 08/25/16 at 8:55 am with a first shift MA revealed: -The DME company was coming today to check the CPAP machine to determine if it could be repaired or it needed to be replaced.</p> <p>B. Review of Resident #1's current FL2 dated 04/12/16 revealed: -Diagnoses of hypertension, mental retardation; schizophrenia, dementia; renal disease, diabetes mellitus, and cardiac failure. -Orders for TED hose apply daily, remove nightly.</p> <p>1. Review of Resident #1's record revealed NP orders for TED hose with measurements dated 01/16/16.</p> <p>Review of Resident #1's Care Plan signed by the Nurse Practitioner (NP) on 07/12/16 revealed: -The Care Plan was prepared by the Resident Care Coordinator (RCC). -Resident #1 was independent and needed no assistance with eating, ambulation, and transferring. -Resident #1 needed limited supervision with toileting, bathing, dressing, and grooming. -The resident totally dependent on facility staff for medication and weekly blood draws. -Resident #1's TED hose was not document as a medically related personal care need.</p>	D 273		

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D 273	<p>Continued From page 29</p> <p>Observation on 08/23/16 at 10:43 am of Resident #1 revealed:</p> <ul style="list-style-type: none"> <li>-The resident was outside sitting in a rocker.</li> <li>-The resident had on knee length pants with TED hose stocking that were pulled up to the resident's calf.</li> <li>-The TED hose stocking on the resident's left leg had a quarter size hole on the side of the resident's leg.</li> <li>-The hole was midway down the resident's leg between her calf and ankle.</li> <li>-The TED hose on the resident's left leg was twisted on the resident's ankle.</li> <li>-The heel of the stocking was on the top of the resident's ankle.</li> <li>-There were several creases in the TED hose by the ankle and above the ankle, because the hose had not been pulled up to straighten them out.</li> <li>-The TED hose were bunched together at the calf where they stopped.</li> <li>-Due to the TED hose being bunched together it could not be determined how much material was gathered at the calf of the resident's leg.</li> <li>-The bunched together TED hose caused the resident's leg to puff out 1/3 inch over the top of the TED hose.</li> <li>-The puffiness in the resident's legs was between the calf and the knee.</li> </ul> <p>Observation on 08/24/16 at 3:50 pm of Resident #1's room with the PCA revealed:</p> <ul style="list-style-type: none"> <li>-The PCA searched the resident's night stand, chest of drawers, closet, and bathroom and found no more TED hose.</li> <li>-No more TED hose were observed in the resident's room.</li> </ul> <p>Review of Resident #1's Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> <li>-TED hose was printed on the MAR, as "Elastic</li> </ul>	D 273		

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D 273	<p>Continued From page 30</p> <p>Bandage &amp; support hose" provide TED hose every morning &amp; remove every evening. -Staff initialed the putting the TED hose on at 6:00 am and removing them at 8:00 pm.</p> <p>Interview on 08/23/16 at 10:45 am with Resident #1 revealed: -She put her TED hose on every morning and took them off before going to bed. -No staff at the facility had asked to assist her with putting the TED hose on or taking them off. -Sometimes facility staff washed them out and put them in the bathroom to dry, but not every night. -She put the TED hose on the same way every day. -The hole in the TED hose had been there for "sometime," a few months. -No staff had ever said that she put them on wrong.</p> <p>Interview on 08/24/16 at 3:53 pm with a second shift PCA revealed: -She had previously seen other pairs of TED hose in the Resident #1's room. -She was unable to find any today, so staff must have thrown them away because they were tattered and worn.</p> <p>Interview on 08/24/16 at 5:00 pm with a second Personal Care Aide (PCA), on the second shift revealed: -Resident #1 likes to do things herself, so she may be putting the TED hose on herself. -Some nights she took Resident #1's TED hose off and washed them out. -She think Resident #1's TED hose had been raggedy for 1 month. -She did not tell anyone about the resident's TED hose being raggedy.</p>	D 273		

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D 273	<p>Continued From page 31</p> <p>-She did not think Resident #1 had another pair of TED hose.</p> <p>-A search of Resident #1's room at the request of the surveyor, she did not observe another pair of TED hose in Resident #1's room.</p> <p>Interview on 08/24/16 at 5:03 pm with the RCC revealed:</p> <p>-Resident #1 was "pretty independent" and tried to dress herself.</p> <p>-The resident probably put the TED hose on herself.</p> <p>-The third shift staff should have checked to ensure the TED hose were on correctly.</p> <p>-The MA was to check to ensure the TED hose were on correctly before initialing the MARs.</p> <p>-Resident #1 may need to be measured again because her legs and ankles have decreased in size.</p> <p>Interview on 08/24/16 at 8:57 am with a representative from the Nurse Practitioner's office revealed:</p> <p>-The NP saw Resident #1 on 08/04/16, there was no information documented regarding the resident's TED hose with hole or being tattered and worn.</p> <p>Confidential interview with a third shift PCA revealed:</p> <p>-Resident #1 did put her own TED hose on without assistance from staff.</p> <p>-She had observed Resident #1's TED hose was raggedy, being tattered and worn, and she reported it in July 2016, to the RCC.</p> <p>2. Review of Resident #1's current FL2 dated 04/12/16 revealed:</p> <p>-Diagnoses of hypertension,</p> <p>-Orders for blood pressure (BP) and pulse daily.</p>	D 273		

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D 273	<p>Continued From page 32</p> <p>-No orders for BP parameters regarding high or low BP.</p> <p>-Orders medication to control BP included: Lisinopril 10mg daily, Hydralazine 100mg three times daily; and furosemide 20mg twice daily.</p> <p>Review of Resident #1's June, July and August 2016 Medication Administration Records (MARs) revealed:</p> <p>-Printed on the MARs was "Check and record blood pressure and pulse daily (notify MD if systolic &gt;180 and diastolic &gt; 90)" 3-11 pm.</p> <p>-No orders for low BP.</p> <p>Staff documented BPs daily from July 1, 2016 through July 31, 2016, on the second shift with no specific time.</p> <p>-Documented BPs on the July 2016 MARs with diastolic less than 60 as follows: -07/02 BP =98/39; 07/03 BP=112/37; 07/05 BP=108/47; 07/08 BP=108/46; 07/11 BP 93/48; 07/12 BP 112/48; 07/13 BP=99/39; 07/15 BP=107/47; 07/16 BP=83/35; 07/19 BP=83/38; 07/21 BP=93/40; 07/31 BP=108/46.</p> <p>Staff documented BPs daily from August 1, 2016 through August 26, 2016, on the second shift with no specific time.</p> <p>-Documented BPs on the July 2016 MARs with diastolic less than 60 as follows: -August 2016 MARs - 08/01 BP 110/56; 08/02 BP 91/39; 08/03 BP 81/57; 08/09 BP 100/50; 08/12 BP 109/55; 08/15 BP 128/50; 08/17 BP 102/49; 08/18 BP 103/48.</p> <p>Interview on 08/24/16 at 4:10 pm with the second shift Medication Aide (MA) revealed:</p> <p>-Resident #1 had orders for daily BP.</p> <p>-The resident's BP was checked on the second shift, 3-11 pm.</p>	D 273		

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D 273	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>-She was aware Resident #1 had several medications to lower her blood pressure.</li> <li>-She was aware the resident had many recorded low BPs.</li> <li>-She had not informed management of the low BPs and had not followed-up with the Nurse Practitioner (NP) to see if some medications should be reduced.</li> <li>-The BP orders on the MARs did not address contacting the NP for low BPs.</li> <li>-When asked by the surveyor to observe her obtaining Resident #1's BP, the MA replied she had not checked Resident #1's blood pressure (BP) since Monday, August 22, 2016, because the BP machine was broken.</li> <li>-The facility did not have another BP cuff for her to check the resident's BP.</li> <li>-She had not notified management the BP machine was broken.</li> </ul> <p>Interview on 08/24/16 at 4:21 pm with the first shift MA/supervisor revealed:</p> <ul style="list-style-type: none"> <li>-She was unaware Resident #1 had low BP readings.</li> <li>-Although, there were no orders for low BP readings staff should have notified her of the readings, so she could follow-up with the NP or check the BP readings to ensure the readings were accurate.</li> <li>-BPs with a diastolic reading in the 30's and 40's should have been reported to her so she could report to NP.</li> <li>-The facility did not have a system of checking the MARs to view BP readings, the MAs should have told her or the RCC.</li> <li>-She was also unaware that Resident #1's BP had not been checked since Monday, August 22, 2016 because the BP machine was not working.</li> <li>-A check of the BP machine with the RCC revealed it was not working.</li> </ul>	D 273		

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D 273	<p>Continued From page 34</p> <p>Interview on 08/24/19 at 4:25 pm with the Resident Care Coordinator (RCC) revealed: -No staff had informed her Resident #1's BPs were in the 30's and 40's. -She had another BP cuff, but it was not available to second shift staff, it was locked in her office. -If the second shift staff had informed her the BP machine was broken she would have checked to get the BP machine fixed. -She would check Resident #1's BP. -A check of Resident #1's BP by the RCC using a manual BP cuff was 140/72.</p> <p>Interview on 08/24/16 at 4:31 pm with Resident #1 revealed: -Staff on the second shift checked her BP daily. -She was unaware of the BP readings, because staff never said what the readings results were. -She felt "fine," she was not light headed or dizzy.</p> <p>Interview on 08/26/16 at 10:52 am with a representative from the Nurse Practitioner's (NP) office revealed: -The NP was on maternity leave, and she did not view any documents related to the facility contacting the NP regarding Resident #1's low BP. -The NP was in the facility on 8/04/16 and saw Resident #1. -There was no documentation regarding Resident #1's BP being low. -She was sure the NP would want to know if the resident's BP readings were low because she was on BP medication.</p> <p>_____</p> <p>A Plan of Protection was provided by the facility on 08/25/16 which included the following: -The Supervisor will ensure the CPAP machine is working properly every night.</p>	D 273		

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D 273	<p>Continued From page 35</p> <ul style="list-style-type: none"> <li>-The Supervisor will also make sure the CPAP machine appliances are applied on the resident.</li> <li>-An inservice was held 08/25/16 with all MA concerning contacting physician and DME with orders for residents.</li> <li>-Every two hours the supervisor and personal care staff will check to make sure the CPAP is working properly and applied to resident throughout the night until the resident is awake for the next day.</li> <li>-The RCC will monitor all physician orders and will order all DME supplies.</li> <li>-The Supervisor /MAs will check residents daily and apply TED hose as ordered.</li> </ul> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 15, 2016.</p>	D 273		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:</p> <ul style="list-style-type: none"> <li>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</li> <li>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</li> </ul> <p>This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to assure implementation of Thrombo-Embolic Deterrent(TED) hose on in the morning and off at bedtime for 2 of 5 sampled residents (#6 and #7).</p>	D 276		

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D 276	<p>Continued From page 36</p> <p>The findings are:</p> <p>A. Review of Resident #7's current FL2 dated 10/20/15 revealed: -Diagnoses of leg deformity, hypertension, and sarcoidosis.</p> <p>Review of Resident #7's record revealed and order from the Nurse Practitioner (NP) dated 07/12/16 for "TED Hose (knee high), apply to BLE in the M and remove at HS."</p> <p>Review of Resident #7's Care Plan prepared by the RCC and signed by the NP on 11/24/15 revealed: -Resident #7 was independent of all Activities of Daily Living with the exception of grooming, the resident needed limited assistance. -The resident was totally dependent on the facility for medications. -TED hose was not documented as a medically related personal care need for Resident #7.</p> <p>Review of Resident #7's July and August 2016 Medication Administration Records (MARs) revealed TED hose was not documented on the MARs.</p> <p>Review of Resident #7's record revealed no Licensed Health Professional Support evaluation related to the resident wearing TED hose.</p> <p>Observation on 08/25/16 at 8:30 am of Resident #7's stockings revealed: -Resident #7 had on beige stockings that did not appear to be TED hose. -The stockings were loose fitting and folded down at the knees with at least three inches of material folded over below the knee.</p>	D 276		

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D 276	<p>Continued From page 37</p> <ul style="list-style-type: none"> <li>-The resident grabbed the stockings by the material folded down at her knee, and pulled them out about 4 inches from her leg.</li> <li>-The heel of the stocking was on the top left side of the resident's foot.</li> <li>-The stocking on the resident's right leg had a 4 inch round hole in the middle of the resident's thigh.</li> <li>-Just below the hole was 3 inches of runs that started out and went down the resident's leg 3 inches to a cone shaped peak.</li> <li>-Both Resident #7's legs were puffy and swollen.</li> <li>-There was no indention from the stocking because they were loose.</li> <li>-Both the resident's legs had a shine and when touched by the resident left an indentation.</li> </ul> <p>Interview on 08/25/16 at 8:30 am with Resident #7 revealed:</p> <ul style="list-style-type: none"> <li>-She put her stockings on every morning without staff assistance, and took them off at night.</li> <li>-No facility staff had offered to assist her with putting the stockings on or taking them off.</li> <li>-She was unaware the NP had ordered TED hose.</li> <li>-She had not worn TED hose since she lived at the facility, but had the stockings that were given to her by a family member.</li> </ul> <p>Observation on 08/30/16 at 10:45 am of Resident #7 revealed:</p> <ul style="list-style-type: none"> <li>-The resident had on black TED hose.</li> <li>-The TED hose on the left leg was twisted at the ankle, with the heel part on top side of the ankle.</li> <li>-The ankle above and below where the TED hose was twisted was puffed ½ inch above the twisted.</li> </ul> <p>Interview on 08/25/16 at 9:41 am with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> <li>-Resident #7's TED hose were custom made due</li> </ul>	D 276		

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D 276	<p>Continued From page 38</p> <p>to the size of the resident's leg.</p> <ul style="list-style-type: none"> <li>-Resident #7's family member was responsible for getting her TED hose.</li> <li>-She had not informed Resident #7's family member the resident needed TED hose, she thought Resident #7 had informed the family member.</li> <li>-Resident #7's TED hose had been ripped and torn for at least three weeks.</li> </ul> <p>Interview on 08/26/16 at 11:50 am with Resident #7's family member revealed:</p> <ul style="list-style-type: none"> <li>-She was Resident #7's guardian.</li> <li>-She moved Resident #7 to the facility in October 2015.</li> <li>-Resident #7 came to the facility with regular support stockings she purchased at the local store.</li> <li>-No one at the facility had told her Resident #7 was ordered TED Hose.</li> <li>-She was also unaware that Resident #7 was putting the support hose on by herself.</li> <li>-Resident #7 was handicapped and had a brace on her right leg that extended from the hip to the foot.</li> <li>-Due to the handicap it would be difficult for Resident #7 to put the support hose on without staff assistance, and the resident definitely could not put TED hose on by herself.</li> <li>-If the facility had informed the family member that Resident #7 had an order for TED she would have purchased the TED hose for Resident #7.</li> </ul> <p>Second Interview on 08/29/16 at 8:35 am with Resident #7's family member/guardian revealed:</p> <ul style="list-style-type: none"> <li>-She went to the facility Saturday to pick up Resident #7.</li> <li>-She observed that both Resident #7's right and left leg were very swollen from knee down to the ankle, and the resident complained they hurt.</li> </ul>	D 276		

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D 276	<p>Continued From page 39</p> <p>-When she touched the resident's leg with her fingers immediately saw white, and her fingers left an indentation on the resident's leg.</p> <p>-The resident's legs were also hot to touch.</p> <p>-She did not inform the staff that was on duty because she was not aware of Resident #7's swollen legs until she got the resident to her house.</p> <p>-She bought Resident #7 a pair of compression stockings when she picked the resident up, because of conversation she had with the surveyor on last Friday (08/26/16).</p> <p>Interview on 08/30/16 at 10:45 am Resident #7 revealed:</p> <p>-She put on her stockings on this morning.</p> <p>-Staff did not assist her, she put on her stockings every morning, and removed them at bed time.</p> <p>-It was hard, but she put them on the best she could.</p> <p>-No, she had not asked staff to help put the stockings on, and no staff had offered to put on the stockings or checked to make sure she put on the stockings.</p> <p>Refer to interview on 08/24/16 at 3:45 pm with a second shift Personal Care Aide (PCA).</p> <p>B. Review of Resident #6's current FL2 dated 04/12/16 revealed:</p> <p>-Diagnoses of hypertension, heart disease, heart failure, mental retardation; dementia, and Type 2 diabetes.</p> <p>-Order for TED hose apply daily, remove nightly.</p> <p>Review of Resident #6's June, July and August 2016 MARs revealed TED hose apply daily and remove nightly was not printed on the MARs.</p> <p>Review of Resident #6's Care Plan prepared by the RCC and signed by the NP on 07/28/15</p>	D 276		

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D 276	<p>Continued From page 40</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-The resident was independent in all Activities of Daily Living.</li> <li>-The resident was totally dependent on facility staff for medication administration and daily fingerstick blood sugars.</li> <li>-TED hose was not documented as a medically related personal care need.</li> </ul> <p>Review of The Licensed Health Professional Support (LHPS) evaluation dated 05/31/16 by the Registered Nurse (RN) revealed:</p> <ul style="list-style-type: none"> <li>-TED hose was documented as task for Resident #6.</li> <li>-The RN documented "neuropathy pain keeps up at night, non-pitting edema of @ calf. Not wearing TED hose."</li> <li>-Recommendations contact MD or wound clinic.</li> </ul> <p>Review of The LHPS evaluation dated 08/18/16 by the RN revealed:</p> <ul style="list-style-type: none"> <li>-TED hose was checked as a task for Resident #6.</li> <li>-The RN documented "reports neuropathy, stabbing in (L) lateral ankle, 1+ firm edema of calves bilateral. Not wearing TED hose."</li> <li>-Recommendations was to report concerns to NP and podiatry.</li> </ul> <p>Review of June, July and August 2016 MARs revealed TED hose was not printed on the MARs.</p> <p>Review of Resident #6's record revealed no documentation the physician was contacted regarding the resident non-compliance with TED.</p> <p>Observation on 08/24/16 at 4:15 pm of Resident #6 revealed:</p> <ul style="list-style-type: none"> <li>-The resident sitting outside in a rocking chair.</li> <li>-The resident had on white socks that came up to</li> </ul>	D 276		

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D 276	<p>Continued From page 41</p> <p>the calf of his leg. -The resident's legs were a little puffy around the ankles.</p> <p>Second observation on 08/30/16 at 10:50 am of Resident #6 revealed: -The resident was sitting outside in a rocker. -The resident had on black socks with a grey ring around the top of the band. -The socks were ribbed and left a slight impression on the resident's leg. -The resident's right ankle was a little more swollen than the resident's left ankle. -The resident's right ankle was a little puffy, with small prints of the socks on his leg. -The left leg did not appear to be puffy or swollen .</p> <p>Observation on 08/30/16 at 11:40 am of the first shift Personal Care Aide (PCA) searching Resident #6's room revealed: -There were three pair of TED hose in the resident's night stand drawer. -Two white pair, one pair appeared to be very dark in color, maybe dirty; and the black pair had holes in the foot area.</p> <p>Interviews on 08/24/16 at 9:16 am, 08/25/16 at 9:20 am, and 08/30/16 at 11:01 am with Resident #6 revealed: -He had a pair of black TED hose that went to the wash, but he had not gotten them back. -That was why he did not have them on today. -The TED hose were put in the wash 2-3 weeks ago and he had not seen them since. -When he had TED hose facility staff did not assist with the TED hose, but he put them on himself. -He wore TED hose because his legs got burned and the TED hose helped with the swelling. -He told the RCC to tell the first shift MA</p>	D 276		

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D 276	<p>Continued From page 42</p> <p>supervisor he needed another pair of TED hose . -He got a brand new pair of TED hose last Thursday, 08/25/16, that were beige. -On Saturday, 08/27/16 at bedtime "the girl took them on to wash, and they didn't come back." -If he had more TED hose in the nightstand drawer, he was unaware. -Yesterday he told the RCC that he could not find his TED hose, and she said that she would order another pair.</p> <p>Interview on 08/25/16 at 11:10 am with Resident #6's responsible person revealed: -She was unaware of the resident's TED Hose whereabouts. -The resident's memory was good and he should know if his TED hose were missing. -She said no one notified or told her the TED hose were not available for the resident to wear. -She thought Resident #6 was ordered TED hose for heart failure and diabetes.</p> <p>Interview on 08/24/16 at 9:34 am with the first shift Medication Aide revealed: -She was unaware Resident #6 was not wearing his TED hose. -Resident #6 was sometimes non-compliant with wearing TED hose. -When she saw Resident #6 not wearing his TED hose she verbally told the resident go to his room and put the TED hose on. -She did not observe the resident to ensure he had put the TED hose on. -She had not notified the Nurse Practitioner the resident was sometimes non-compliant with wearing his TED hose.</p> <p>Second interview on 08/25/16 at 9:30 am with the first shift Medication Aide/Supervisor revealed: -Yesterday (08/24/16) she ordered Resident #6 a</p>	D 276		

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D 276	<p>Continued From page 43</p> <p>new pair of TED hose.</p> <p>-Staff were not letting her know when Resident #6 did not have TED hose on or was not wearing TED hose.</p> <p>-The third shift staff were responsible for assisting Resident #6 with putting on his TED hose.</p> <p>-The Medication Aide on the first shift was to view the resident with the TED hose on to ensure the TED hose were on properly.</p> <p>-The Medication Aide (MA) initialed the Medication Administration Record (MAR) that TED hose were on in the morning.</p> <p>-The same was to occur in the evening with the second shift PCA removing the TED hose and the MA observing and documenting the TED hose were removed.</p> <p>Interview on 08/30/16 at 11:43 am with a first shift PCA revealed:</p> <p>-The PCA that worked on third shift was supposed to ensure Resident #6 TED hose were put on.</p> <p>-The Medication Aide was to observe the resident wearing the TED hose and ensure the TED hose were on correctly.</p> <p>Interview on 08/24/16 at 8:20 am with the Personal Care Aide (PCA) revealed:</p> <p>-She worked the third shift and did not put Resident #6's TED hose on.</p> <p>-Resident #6 put his own TED hose on.</p> <p>-No one had directed her put Resident #6's TED hose on.</p> <p>Interview on 08/26/16 at 10:52 am with a representative from the Nurse Practitioner's (NP) office revealed:</p> <p>-The NP was on maternity leave, and she did not find any documents related to the facility contacting the NP regarding Resident #6</p>	D 276		

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D 276	<p>Continued From page 44</p> <p>non-compliance with wearing TED hose. -She was sure the NP would want to know if the resident was non-compliant with wearing TED hose.</p> <p>Interview on 08/30/16 at 11:54 am with the NP that was filling-in revealed: -She previously seen residents at the facility, it had almost been one year ago. -Staff gave her a list of many residents to see this morning, but no one had informed her that Resident #6 was non-compliant with wearing TED hose. -Staff were expected to ensure TED hose were implemented and if the resident verbally refused, then notify the NP, but they should initiate putting the TED hose on.</p> <p>Refer to interview on 08/24/16 at 3:45 pm with a second shift Personal Care Aide (PCA).</p> <p>Interview on 08/24/16 at 3:45 pm with a second shift PCA revealed: -PCAs on the second shift were responsible for taking residents TED hose off. -The PCAs were to wash out the TED hose and let the MA know they removed the TED hose. -The MA initialed the MARs showing the TED hose were removed. -If the resident was not wearing TED hose when she came to the room, she told the MA the TED hose were off. -She was unaware if the resident had TED hose on during the day, she just observed the hose were off, and that was what she told the MA.</p>	D 276		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights</p>	D 338		

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D 338	<p>Continued From page 45</p> <p>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: Based on record review, observation, interviews the facility failed to assure residents were treated with respect, dignity, and full recognition of their individually by staff yelling and talking harsh to residents, wheelchairs needing repair, protecting residents from bed bug bites.</p> <p>The findings are:</p> <p>A Review of Resident #12's current FL2 dated 5/10/16 revealed diagnoses included chronic obstructive pulmonary disease, chronic kidney disease, and hypertension.</p> <p>Interview on 8/24/16 at 4:30 pm with Resident #12 revealed: -She had been bitten by bed bugs while she was sleeping in May 2016. -She told staff she was itching where the bed bugs had bitten her on the back. -The doctor had prescribed a cream, and staff had applied it to her back. -She currently had bites on her back again, but had not told the staff she had been bitten. -"The bed bugs are biting me on my back while I sleep."</p> <p>Observation on 8/24/16 of Resident #12's back revealed multiple raised red areas to top of the back with what appeared to be scratches across the back area from Resdient #12's scratching.</p> <p>Interview on 8/24/16 at 4:50 with a Medication</p>	D 338		

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D 338	<p>Continued From page 46</p> <p>Aide revealed: -She was aware Resident #12 had a rash to her back in May 2016. -Resident #12 never told her she was bitten by bed bugs. -She had informed the Nurse Practitioner (NP) Resident #12 had a rash and was itching in May 2016. -The NP prescribed hydrocortisone cream for the itching. -She remembered applying the cream to Resident #12's back until the rash was healed in June 2106.</p> <p>Review of Resident #12's record revealed: -A signed physican order dated 5/10/16 for Hydrocortisone 1% cream (a steroid used to treat itching and inflammation) to back two times daily until healed. -A diagnoses of pruritus (itching to the skin).</p> <p>Attempted interview on 8/25/16 at 9:00 am with the prescribing Nurse Practitioner was unsuccessful.</p> <p>Interview on 8/25/16 at 9:15 am with the nurse from the primary care physician's office revealed: -On 5/10/16 the NP had seen Resident #12 in the facility. -An order was written for Resident #12 on 5/10/16 for hydrocortisone cream 1% to the back two times daily until healed. -There was no documentation in the NP notes concerning bed bugs or that Resident #12 had been bitten by bed bugs. -There was no documentation in the notes the NP was aware bed bugs were in the facility.</p> <p>Telephone interview on 9/6/16 at 9:00 am with the facility pharmacy revealed:</p>	D 338		

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D 338	<p>Continued From page 47</p> <p>-A tube of hydrocortisone 1% cream apply two times daily was dispensed on 5/11/16 and again on 6/17/16. -The hydrocortisone cream was discontinued on 7/21/16.</p> <p>Review of the May 2016 Medication Administration Record (MAR) for Resident #12 revealed; -A handwritten entry for hydrocortisone 1% cream apply to back until healed. -No entry for frequency of administration of the hydrocortisone cream. -Documentation hydrocortisone cream was administered on 5/12/16 -5/30/16 once during the day.</p> <p>Review of the June 2016 Medication Administration Record (MAR) for Resident #12 revealed: -There was a pharmacy generated MAR with an entry for hydrocortisone cream 1% to apply to posterior neck and posterior ears twice daily at 8:00 am and 8:00 pm until healed. -Documented initialed entry the hydrocortisone cream was applied 6/1/16 at 8:00 am and 8:00 pm through 6/15/16 at 8:00 am. -Hand written documentation on the MAR on 6/15/16 "Healed".</p> <p>Refer to confidential telephone interview on 8/29/16 at 11:00 am with a family member.</p> <p>Refer to confidential interviews on 8/23/16 between 10:00 am and 6:00 pm with facility staff.</p> <p>Refer to interview on 8/30/16 with the Administrator Assistant revealed:</p> <p>Refer to interview on 8/23/16 at 10:40 am and</p>	D 338		

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D 338	<p>Continued From page 48</p> <p>2:10 pm with the Administrator.</p> <p>2. Review of Resident #11's current FL2 dated 8/15/16 revealed diagnoses that included congestive heart failure, hypertension, and diabetes.</p> <p>Interview on 8/24/16 at 4:10 pm with Resident #11 revealed:</p> <ul style="list-style-type: none"> <li>-He lived in the facility for about a year.</li> <li>-He was aware bed bugs were in the facility and had told staff bed bugs were in the facility.</li> <li>-He had been bitten at night by bed bugs sometime in September 2015.</li> <li>-His family had taken him to see the doctor about the bites on his arms.</li> <li>-The doctor gave him " a pill for the itching".</li> <li>-The maintenance man had sprayed his room and took the mattresses out in September 2015.</li> <li>-The staff put plastic covers on the new mattress after they took the old ones out.</li> <li>-He sometimes still got bitten at night, "The bed bugs are hard to kill".</li> </ul> <p>Telephone interview on 8/29/16 at 11:40 am with the nurse from Resident #11's physican's office revealed:</p> <ul style="list-style-type: none"> <li>-Resident #11 had seen the Physican Assistant (PA) on 9/9/15 in the office for itching.</li> <li>-The PA had written a prescription date 9/9/15 for Hydroxyzine 25 mg as needed for itching.</li> <li>-No documentation in the PA's notes Resident #11 had been bitten from bed bugs.</li> </ul> <p>Review of Resident #11's record revealed no documentation the family had taken Resident #11 to the physican's office in September 2015, nor were there any notes from the physican's office.</p> <p>Interview on 8/25/16 at 2:45 pm with the Resident</p>	D 338		

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D 338	<p>Continued From page 49</p> <p>Care Coordinator (RCC) revealed: -She was aware Resident #11's family had taken him to the physican's office for all visits. -The family did not bring the physican's information for the facility record to the facility. -"The family tells the Administrator Assistant or the MA of any new orders or medication changes for Resident #11." -The RCC was unaware the information obtained by Resident #11's family from the physican's office was part of Resident #11's facility record.</p> <p>Interview on 8/29/16 at 10:50 am with a family member for Resident #11 revealed: -On 9/9/15 the family member had taken Resident #11 to the physican office for bed bug bites to his body. -The physican had written a prescription for hydroxyzine 25 mg for itching. -The family member had given the prescription to the Adminstrator Assistant (AA) when Resident #11 returned to the facility.</p> <p>Telephone interview on 9/6/16 at 9:00 am with the facility pharmacy representative revealed no order for hydroxyzine 25 mg every 8 hours as needed was received or dispensed by the facility pharmacy.</p> <p>Review of Resident #11's Medication Administration Record (MAR) for September 2015 revealed: -One page was submitted for review and there was no entry for hydroxyzine 25 mg every 8 hours as needed.</p> <p>Review of Resident #11's Mars for the month of October, November, and December 2015, revealed no entry for hydroxyzine 25 mg every 8 hours as needed.</p>	D 338		

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D 338	<p>Continued From page 50</p> <p>Refer to confidential telephone interview on 8/29/16 at 11:00 am with a family member.</p> <p>Refer to confidential interview on 8/23/16 between 10:00 am and 6:00 pm with facility staff.</p> <p>Refer to interview on 8/30/16 with the Administrator Assistant revealed:</p> <p>Refer to interview on 8/23/16 at 10:40 am and 2:10 pm with the Administrator.</p> <p>_____</p> <p>Confidential telephone interview on 8/29/16 at 11:00 am with a residents' family member revealed:</p> <ul style="list-style-type: none"> <li>-She visited at the facility several times monthly.</li> <li>-She was aware bed bugs were in the facility, and had been in the facility for about a year.</li> <li>-She was told by the residents there were bed bugs in their room.</li> <li>-She was told by a resident the bed bugs had bitten them at night.</li> <li>-She told the Assistant Administrator and the Administrator the resident had been bitten by bed bugs in their room.</li> <li>-To her knowledge in the past year, this was the third time pest control had been out to treat the bed bugs.</li> <li>-The Administrator had staff remove old mattresses and bought a new mattresses with a plastic mattress covers about 6 months ago.</li> <li>-The maintenance man sprayed rooms and staff washed the resident's clothes, but she was not sure if all the resident's clothes in the closet was laundered.</li> <li>-She informed the resident not to sit in the chairs in the common area, "I think the bed bugs are in the common area chairs."</li> </ul>	D 338		

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D 338	<p>Continued From page 51</p> <ul style="list-style-type: none"> <li>-Last week the resident complained again of bed bugs bites.</li> <li>-"The bed bugs keep coming back."</li> </ul> <p>Confidential interviews with six facility staff revealed:</p> <ul style="list-style-type: none"> <li>-They were aware the facility had bed bugs and it had been going on for about 2 years.</li> <li>-The bed bugs had been seen in every room and in the common areas.</li> <li>-Residents had complained they had been bitten on several occasions.</li> <li>-They would inform the Medication Aides (MA), Residents care Coordinator (RCC), Assistant Administrator (AA), and the Administrator.</li> <li>-They would slip notes under the door of the Administrator if she was not working or if it was the weekend.</li> <li>-"The bed bugs keep coming back."</li> <li>-Staff had been bitten on several occasions.</li> <li>-Staff had bed bugs in their home, they were not sure if the bed bugs came from the facility.</li> <li>-Family members had complained to them the residents were getting bitten at night.</li> <li>-Staff never sat in the chairs in the common area due to bed bugs in the furniture.</li> <li>-Staff had no education or training on bed bugs.</li> </ul> <p>Interview on 8/30/16 with the Administrator Assistant revealed:</p> <ul style="list-style-type: none"> <li>-Two family members had came to her with concerns the residents' were being bitten by bed bugs.</li> <li>-There were no documented notes from the physican office stating residents were actually being bitten by bed bugs.</li> <li>-Each time a family member came to her concerning bed bugs and residents being bitten, she would communicate with the Administrator.</li> </ul>	D 338		

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D 338	<p>Continued From page 52</p> <p>Interview on 8/23/16 at 10:40 am and 2:10 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-She was unaware resident rooms or the facility had bed bugs.</li> <li>-"One staff person complained of bed bug bites in June 2016, that's why I called the pest control company."</li> <li>-Was not aware of any residents in the facility who had been bitten by bed bugs.</li> <li>-No residents had been treated for bed bug bites.</li> <li>-No family complained to her about bed bugs in the facility.</li> </ul> <p>B. Observation on 8/23/16 between 9:18 am and 11:30 am during the initial tour revealed the facility library doors were locked.</p> <p>Confidential interviews with staff revealed:</p> <ul style="list-style-type: none"> <li>-The library doors were always locked.</li> <li>-The Medication Aides (MA) and Resident Care Coordinator (RCC) had keys to the library.</li> <li>-There were new chairs and furniture in the library.</li> <li>-The library was used by the Administrator for possible new admissions and their family, "It's kept nice for them".</li> <li>-The residents were not allowed to go into the library.</li> <li>-Residents were eating in the library and staff were told by management not to allow residents in the library unless staff were with them.</li> <li>-Residents could get a book or magazine from the library, but were not allowed to sit in the chairs in the library.</li> </ul> <p>Confidential interviews with 3 residents revealed:</p> <ul style="list-style-type: none"> <li>-"We cannot go into the library; the doors are always locked."</li> <li>-"I would like to go into the library and get a book and sit."</li> </ul>	D 338		

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D 338	<p>Continued From page 53</p> <ul style="list-style-type: none"> <li>-They were told some residents were eating in the library, that was why they could not go in the library now.</li> <li>-"I would like to go in the library it looks pretty and quiet."</li> <li>-"I've ask to go into the library but was told no."</li> </ul> <p>Observation on 8/23/16, 8/24/16, and 8/25/16 during the survey revealed the library doors were locked.</p> <p>Interview 8/25/16 at 3:45 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-She was aware the library doors were locked, which prevented residents from entering the library freely.</li> <li>-Residents could go into the library but staff had to let them in with a key.</li> <li>-The MAs and the RCC had keys to the library.</li> <li>-She had purchased new furniture for the library about 6 months ago.</li> <li>-Residents were eating in the library and leaving food which could cause ants.</li> <li>-Signs were in every resident's room and the library, "No food in the room."</li> <li>-No family or resident had complained to her about the library being locked.</li> </ul> <p>C. Confidential interviews with six residents revealed:</p> <ul style="list-style-type: none"> <li>-One resident said Staff B and Staff C were abusive, not physical, but more mental, and verbal (not cursing).</li> <li>-The resident said Staff B and C yelled and talked in harsh tone with a high pitched voice when communicating to residents.</li> <li>-An example of how Staff B and C were mentally abusive was: a resident in a wheelchair got annoyed when people bumped into or pushed the wheelchair, and just to annoy the resident Staff B</li> </ul>	D 338		

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D 338	<p>Continued From page 54</p> <p>and C walked by the resident and bumped her wheelchair with their hip.</p> <p>-The resident always got upset or got angry.</p> <p>-Another example of how Staff B and C were mentally abusive to residents: there was a male resident that was confused and wandered up and down the hallway because he needed directions, she had observed on several occasions that both Staff B and C pushed the resident out of their way, instead of asking him to move or gently moving the resident to the other side of the hallway because he was confused.</p> <p>-Staff B and C physically had not touched her, but the tone of their voice made their words sound harsh and threatening.</p> <p>-Both Staffs B and C had started acting better since she reported them to the Assistant Administrator last month.</p> <p>-Staff B and C still were not gentle with residents and residents were uncomfortable when the two staff came around them.</p> <p>-When Staff B and C came around, some residents would stick out their tongue behind their backs because they did not like how Staff B and C treated them, and some residents would not talk when Staff B and C were near them.</p> <p>-Most residents would not talk or tell on staff because when staff realized a resident complained about them they don't verbally say anything to the resident, but they would ignore them and not respond when asked for help.</p> <p>-She complained to the Assistant Administrator in July 2016 (can't recall specific date) about the both Staff B and C.</p> <p>-The Assistant Administrator told her that she would write a report to the Administrator.</p> <p>-She was concerned because the Administrator was not an easy person to communicate with at times.</p> <p>-A second resident said some facility staff were</p>	D 338		

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D 338	<p>Continued From page 55</p> <p>mean to them and yelled at them, but he preferred not to say their names for fear of retaliation.</p> <p>-A third resident said that all staff hired within the past year were young females and did not respect residents.</p> <p>-Staff yelled and talked to residents in harsh tones.</p> <p>-She did not want to give specific staff names, but stated all staff hired within the past year were disrespectful to the residents.</p> <p>-A fourth resident revealed she had an incident with Staff B, but would not hold her tongue and Staff B was aware that she would speak up for herself.</p> <p>-A fifth resident stated most of the staff working at the facility were good to her, but there was one staff that was bad, and that was Staff B.</p> <p>-The young "ones" (staff), like Staff B, were "hateful," and don't give enough help at bath time.</p> <p>-No staff "had ever hurt me or anything like that". The older staff were fine.</p> <p>-A sixth resident said there was one PCA that yelled at her and told her to get out of her way (she did not want to say the staff's name).</p> <p>-She had observed Staff B was "mean" to another resident.</p> <p>Interview on 08/25/16 at 11:41 am with the Assistant Administrator (AA) revealed:</p> <p>-When she got complaints, she typed up a report and gave it to the Administrator.</p> <p>-Then both she and the Administrator investigated, by meeting with the complainant and then talking to the person the complaint was against.</p> <p>-Two weeks ago she got a complaint from a resident regarding Staff B speaking harsh to a resident.</p> <p>-She typed up the report and gave it to the</p>	D 338		

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D 338	<p>Continued From page 56</p> <p>Administrator.</p> <p>-She was unaware if the Administrator had talked with Staff B because she was on vacation the last two weeks.</p> <p>Interview on 08/25/16 at 1:55 pm with Staff B revealed:</p> <p>-In July 2016 there was an incident with Resident #8.</p> <p>-She recalled going into Resident #8's room and she told the resident it was time to get up, and the resident yelled at her "I am in pain."</p> <p>-She immediately left the room and got the RCC.</p> <p>-Until this conversation, no one at the facility had discussed with her the incident regarding Resident #8.</p> <p>-No one at the facility had discussed with her any issues or addressed her behaviors toward residents.</p> <p>-Second interview on 08/25/16 at 3:10 pm with the AA revealed:</p> <p>-Another resident had complained to her that Staff B and C were abusive to her and other residents.</p> <p>-She did not type up the complaint in a report for the Administrator.</p> <p>-She did verbally inform the Administrator, but was unaware if the administrator had any conversations with Staff B and C.</p> <p>Interview on 08/25/16 at 1:05 pm with the Administrator revealed:</p> <p>-She was aware in July 2016 a resident complained about Staff B.</p> <p>-She was not aware of any other complaints regarding Staff B.</p> <p>-She did not investigate, but had a verb conversation with Staff B regarding the tone in her voice.</p>	D 338		

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D 338	<p>Continued From page 57</p> <p>-On 08/03/16 she talked with Staff B about lowering her voice when she talk to residents, because she sometimes sounded harsh or like she was yelling when communicating with residents.</p> <p>-She did not document her conversation with Staff B regarding the tone in her voice and how to communicate with the residents.</p> <p>-She did not think the incident regarding Staff B needed to be reported to the Personal Health Care Personnel Registry.</p> <p>Interview on 08/25/16 at 1:55 pm with Staff B revealed:</p> <p>-To her knowledge no residents had complained to her regarding her behavior.</p> <p>-No management at the facility had talked with her about complaints.</p> <p>-She was unable to recall any incidents with residents where she raised her voice or talked ruff to a resident.</p> <p>Interview on 08/25/16 at 2:55 pm with Resident #8 revealed:</p> <p>-She did not like how Staff B yelled at her, so she told the AA.</p> <p>-Staff B knew that she was not afraid of her and she would speak up for herself.</p> <p>Interview on 08/30/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed:</p> <p>-There was an incident with Resident #8 and Staff B.</p> <p>-One day last month (July 2016, can't recall specific date) she was in the hallway and heard Resident #8 screaming and yelling.</p> <p>-She went to the resident's room to find out what was happening, and the resident told her she was in pain, and Staff B told her she had to get-up.</p> <p>-She offered the resident pain medication.</p>	D 338		

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D 338	<p>Continued From page 58</p> <p>-To her knowledge no one had complained about Staff B before this incident.</p> <p>Confidential interview with two staff revealed:</p> <p>-Initially, they were afraid to talk because the Administrator was near and were afraid of getting fired.</p> <p>-Both staff said Staff C was not that bad, they had not observed Staff C treating residents bad.</p> <p>-Both staff said, Staff B talked to residents "smart" mouth, yelled and argued, and said harsh words.</p> <p>-They had not observed Staff B hit residents, but they were aware residents did not like the way Staff B treated them.</p> <p>-Both staff were sure the Administrator was aware of Staff B's attitude toward residents.</p> <p>D. Observation on 08/23/16 from 12:00 pm to 1:00 pm of the lunch meal revealed:</p> <p>-The lunch meal consisted of: Swiss steak with gravy, lima beans mixed with corn, carrots, cornbread, tea, water, and lime green Jello.</p> <p>-36 residents were present for the meal.</p> <p>-3 residents (#15, #17, and #18,) were given plastic spoons to eat their meal.</p> <p>-Residents #15 and #16 struggled to cut their meat with the plastic spoon.</p> <p>-Resident #15 held the spoon by the beginning of plastic curve in the spoon and moved his hand back and forth in a repetitive sawing motion trying to cut the Swiss steak.</p> <p>-The spoon did not break but appeared to bend from the pressure the resident used trying to cut the meat.</p> <p>-Resident #15 did not hold his head up more than 4 inches from his plate, and scooped the meat in his mouth after each cut.</p> <p>-Resident #15 repeated this process until all the meat was gone.</p>	D 338		

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D 338	<p>Continued From page 59</p> <ul style="list-style-type: none"> <li>-Resident #15 had gravy all over this fingers and hand from cutting up the meat.</li> <li>-In attempt to cut-up her Swiss steak Resident #16 held the curved part of the plastic spoon with her thumb and fore-finger.</li> <li>-Resident #16 pressed down on the meat with force and slowly moved the spoon back and forth across the meat to keep the meat and plate from moving on the table.</li> <li>-The resident repeated this process until all the meat was gone.</li> <li>-The spoon did bend from the pressure the resident used to cut the meat, but did not crack or break.</li> <li>-The resident repeated the process until all the meat was gone.</li> <li>-Resident #17 was given a plastic spoon to eat his meal, but a Personal Care Aide (PCA) used the resident's plastic spoon and a metal non-disposal spoon to cut-up the resident's meat.</li> <li>-Resident #17 was given direction from the PCA to use the plastic spoon to consume his meal.</li> <li>-The PCA directed the resident throughout the meal to eat using the plastic spoon.</li> <li>-After the meal the PCA assisted Resident #17 from the dining room table.</li> </ul> <p>Interview on 08/23/16 at 1:01 pm with the PCA that provided feeding assistance to Resident #17 revealed:</p> <ul style="list-style-type: none"> <li>-Three residents (#15, #16, and #17) in the dining were giving a plastic spoon only at each meal.</li> <li>-She did not know why the residents were only allowed a plastic spoon to consume their meals.</li> <li>-The directions to give the residents plastic spoons only came from the Resident Care Coordinator (RCC).</li> <li>-Some days Resident #17 did not need staff assistance with meals, but today the resident needed staff cueing.</li> </ul>	D 338		

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D 338	<p>Continued From page 60</p> <ul style="list-style-type: none"> <li>-She used the metal spoon to assist with cutting the resident's meat because the plastic spoon could not cut the meat and she was afraid it would crack or break.</li> <li>-She did not think to ask or offered assistance to cut-up residents #15 and #16's meat.</li> </ul> <p>Interview on 08/23/16 at 12:45 pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> <li>-She told staff to give Residents #15, #16, and #17 plastic spoons because the residents take the regular spoons out of the dining room.</li> <li>-The residents take the metal spoons to their room or will hide them on their person.</li> <li>-The residents all have memory problems and do not do anything with the spoons, but the dining room was short of spoons.</li> <li>-She was unaware residents could not have plastic.</li> </ul> <p>Based on record review, observation, and attempt interview on 08/23/16 it was determined Resident #15 was not interviewable.</p> <p>Based on record review, observation and attempt interview on 08/23/16 it was determined Resident #17 was not interviewable.</p> <p>Interview on 08/23/16 at 11:55 am with Resident #16 revealed:</p> <ul style="list-style-type: none"> <li>-Some days she was given a plastic spoon to consume meals and some days not.</li> <li>-She did not know she why was given a plastic spoon to consume her meal.</li> <li>-The plastic spoon was not easy to use.</li> <li>-She thought maybe they ran out of "dishes."</li> <li>-The meal was good and she had not inquired why she was the only person at the table with the plastic spoon.</li> <li>-The other spoon (metal) at some meals would</li> </ul>	D 338		

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D 338	<p>Continued From page 61</p> <p>be better.</p> <p>E. Review of Resident #9's current FL2 dated 04/12/16 revealed: -Diagnoses of metabolic syndrome, malnutrition, weakness, and falls. -Resident was ambulatory with wheelchair.</p> <p>Observation on 08/25/16 at 8:45 am of Resident #9's wheelchair revealed: -The leather covering on the left arm of the wheelchair was torn off from the beginning of the arm base to the end, which was about 1 foot in length, and hanging down on the side of the wheelchair. -The inside padding and cushion for the arm of the wheelchair was gone, and the smooth hard plastic on top of the metal wheelchair frame was showing. -The resident's arm was resting on the smooth hard plastic. -A small imprint from the hard plastic was imprinted on the resident's left arm.</p> <p>Based on record review, observation and attempted interview on 08/25/16 it was determined that Resident #9 was not interviewable.</p> <p>Refer to interview on 08/25/16 at 8:55 am with the Personal Care Aid (PCA).</p> <p>Refer to interview on 08/25/16 at 9:43 am with the Resident Care Coordinator (RCC).</p> <p>F. Review of Resident #8's current FL2 dated 08/02/16 revealed: -Diagnoses of hypotensive heart disease, Type 2 diabetes mellitus, hyperlipidemia, osteoporosis; and contracture of muscle.</p>	D 338		

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D 338	<p>Continued From page 62</p> <p>-Ambulation status was ambulatory with a wheelchair.</p> <p>Observation on 08/25/16 at 8:57 am of Resident #8's wheelchair revealed: -The leather covering of the padding on the right arm of the resident's wheelchair was cracked and rough. -The inner white lining was showing.</p> <p>Interview on 08/25/16 at 8:59 am with Resident #8 revealed: -The right arm of her wheelchair had been cracked with the white lining showing for at least one year. -The roughness from the cracks in the wheelchair did not really bother her because she was aware how to place her arm on the wheelchair. -She had not mentioned the crack and roughness of the wheelchair arm to anyone at the facility.</p> <p>Interview on 08/26/16 at 10:39 am with Resident #8's family member revealed: -Resident #8 had been in a wheelchair for 3-4 years. -No one at the facility had talked to him at the resident's wheelchair. -He asked the resident about the cracks and torn areas on the arm of her wheelchair.</p> <p>Refer to interview on 08/25/16 at 8:55 am with the first shift Personal Care Aide (PCA).</p> <p>Refer to interview on 08/25/16 at 9:43 am with the Resident Care Coordinator (RCC).</p> <p>Interview on 08/25/16 at 8:55 am with the first shift PCA revealed: -She reported wheelchairs needing repairs to the first shift Medication Aide/Supervisor.</p>	D 338		

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D 338	Continued From page 63  -The supervisor will call the company where the wheelchair was ordered to get repaired.  Interview on 08/25/16 at 9:43 am with the RCC revealed: -Ensuring wheelchairs were repaired as needed was her responsibility. -She had not observed Residents #8 or #9 wheelchairs, and was unaware of any wheelchairs that needed to be repaired.	D 338		
D 367	10A NCAC 13F .1004(j) Medication Administration  10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).  This Rule is not met as evidenced by: Based on record review, and interviews, the	D 367		

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D 367	<p>Continued From page 64</p> <p>facility failed to assure the Medication Administration Records (MARs) were accurate, related to applying and removing 1 of 5 sampled residents (Resident #1) Thrombo-Embolic Deterrent (TED) hose.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 04/12/16 revealed: -Diagnoses of hypertension, mental retardation; schizophrenia, dementia; renal disease, diabetes mellitus, and cardiac failure. -Orders on the FL2 for TED hose apply daily, remove nightly.</p> <p>Review of Resident #1's record revealed a Nurse Practitioner (NP) order for TED hose with measurements dated 01/16/16.</p> <p>Observation on 08/23/16 at 10:43 am of Resident #1 revealed: -The resident was outside sitting in a rocker. -The resident had on knee length pants with TED hose stocking that were pulled up to the resident's calf. -The TED hose stocking on the resident's left leg had a quarter size hole on the side of the resident's leg TED hose. -The hole was midway down the resident's leg between the calf and ankle. -The TED hose on the resident's left leg was twisted on the resident's ankle. -The heel of the stocking was on the top of the resident's ankle. -There were several creases in the TED hose by the ankle and above the ankle, because the hose had not been pulled up to straighten them out. -The TED hose were bunched together at the calf where they stopped.</p>	D 367		

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D 367	<p>Continued From page 65</p> <ul style="list-style-type: none"> <li>-Due to the TED hose being bunched together it could not be determined how much material was gathered at the calf of the resident's leg.</li> <li>-The bunched together TED hose caused the resident's leg to puff out 1/3 inch over the top of the TED hose.</li> <li>-The puffiness in the resident's legs was between the calf and the knee.</li> </ul> <p>Observation on 08/24/16 at 3:50 pm of Resident #1's room with a PCA revealed:</p> <ul style="list-style-type: none"> <li>-The PCA searched the resident's night stand, chest of drawers, closet, and bathroom and found no more TED hose.</li> <li>-No more TED hose were observed in the resident's room.</li> </ul> <p>Review of Resident #1's June, July and August 2016 Medication Administration Record (MAR) revealed:</p> <ul style="list-style-type: none"> <li>-TED hose was printed on the MAR, as "Elastic Bandage &amp; support hose" provide TED hose every morning &amp; remove every evening.</li> <li>-Staff documented with initials TED hose on at 6:00 am and removed at 8:00 pm.</li> </ul> <p>Interview on 08/23/16 at 10:45 am with Resident #1 revealed:</p> <ul style="list-style-type: none"> <li>-She put her TED hose on every morning and took them off before going to bed.</li> <li>-No staff at the facility had asked to assist her with putting the TED hose on or taking them off.</li> <li>-She put the TED hose on the same way every day.</li> <li>-No staff had ever said that she put them on wrong.</li> </ul> <p>Interview on 08/24/16 at 5:00 pm with the second shift Personal Care Aide (PCA) revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 liked to do things herself, so she</li> </ul>	D 367		

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D 367	<p>Continued From page 66</p> <p>may be putting the TED hose on herself. -Some nights she took Resident #1's TED hose off and washed them out.</p> <p>Interview on 08/24/16 at 5:03 pm with the Resident Care Coordinator (RCC) revealed: -Resident #1 was "pretty independent" and tried to dress herself. -The resident probably put the TED hose on herself. -The third shift staff should have checked to ensure the TED hose were on correctly. -Prior to documenting on the MAR the MA was to check to ensure TED hose were applied correctly.</p> <p>Confidential interview with a PCA revealed: -Resident #1 did put her own TED hose on without assistance from staff.</p>	D 367		
D 438	<p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report suspected resident abuse related to alleged staff (Staff B and C) being verbally and mentally abusive on several occasions to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of the events and for failure to complete the 5 day report to the HCPR.</p>	D 438		

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NAME OF PROVIDER OR SUPPLIER  <b>ST GALES ESTATES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405</b>
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D 438	<p>Continued From page 67</p> <p>The findings are:</p> <p>Confidential interviews with six residents revealed:</p> <ul style="list-style-type: none"> <li>-One resident said Staff B and Staff C were abusive, not physical, but more mental, and verbal (not cursing).</li> <li>-The resident said Staff B and C yelled and talked in harsh tone with a high pitched voice when communicating to residents.</li> <li>-An example of how Staff B and C were mentally abusive was: a resident in a wheelchair got annoyed when people bumped into or pushed the wheelchair, and just to annoy the resident Staff B and C walked by the resident and bumped her wheelchair with their hip.</li> <li>-The resident always got upset or got angry.</li> <li>-Another example of how Staff B and C were mentally abusive to residents: there was a male resident that was confused and wandered up and down the hallway because he needed directions, she had observed on several occasions that both Staff B and C pushed the resident out of their way, instead of asking him to move or gently moving the resident to the other side of the hallway because he was confused.</li> <li>-Staff B and C physically had not touched her, but the tone of their voice made their words sound harsh and threatening.</li> <li>-Both Staffs B and C had started acting better since she reported them to the Assistant Administrator last month.</li> <li>-Staff B and C still were not gentle with residents and residents were uncomfortable when the two staff came around them.</li> <li>-When Staff B and C came around, some residents would stick out their tongue behind their backs because they did not like how Staff B and C treated them, and some residents would not</li> </ul>	D 438		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL041023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/30/2016</b>
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D 438	<p>Continued From page 68</p> <p>talk when Staff B and C were near them.</p> <p>-Most residents would not talk or tell on staff because when staff realized a resident complained about them they don't verbally say anything to the resident, but they would ignore them and not respond when asked for help.</p> <p>-She complained to the Assistant Administrator in July 2016 (can't recall specific date) about the both Staff B and C.</p> <p>-The Assistant Administrator told her that she would write a report to the Administrator.</p> <p>-She was concerned because the Administrator was not an easy person to communicate with at times.</p> <p>-A second resident said some facility staff were mean to them and yelled at them, but he preferred not to say their names for fear of retaliation.</p> <p>-A third resident said that all staff hired within the past year were young females and did not respect residents.</p> <p>-Staff yelled and talked to residents in harsh tones.</p> <p>-She did not want to give specific staff names, but stated all staff hired within the past year were disrespectful to the residents.</p> <p>-A fourth resident revealed she had an incident with Staff B, but would not hold her tongue and Staff B was aware that she would speak up for herself.</p> <p>-A fifth resident stated most of the staff working at the facility were good to her, but there was one staff that was bad, and that was Staff B.</p> <p>-The young "ones" (staff), like Staff B, were "hateful," and don't give enough help at bath time.</p> <p>-No staff "had ever hurt me or anything like that". The older staff were fine.</p> <p>-A sixth resident said there was one PCA that yelled at her and told her to get out of her way (she did not want to say the staff's name).</p>	D 438		

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D 438	<p>Continued From page 69</p> <p>-She had observed Staff B was "mean" to another resident.</p> <p>Interview on 08/25/16 at 11:41 am with the Assistant Administrator (AA) revealed:</p> <p>-Two weeks ago she got a complaint from a resident regarding Staff B speaking harsh to a resident.</p> <p>-She typed up the report and gave it to the Administrator.</p> <p>-She was unaware if the Administrator had talked with Staff B because she was on vacation the last two weeks.</p> <p>-Second interview on 08/25/16 at 3:10 pm with the AA revealed:</p> <p>-Another resident had complained to her that Staff B and C were abusive to her and other residents.</p> <p>-She did not type up the complaint in a report for the Administrator.</p> <p>-She did verbally inform the Administrator, but unaware if the administrator had any conversations with Staff B and C.</p> <p>Interview on 08/25/16 at 1:05 pm with the Administrator revealed:</p> <p>-She was aware in July 2016, a resident complained about Staff B.</p> <p>-She was not aware of any other complaints regarding Staff B and C.</p> <p>-She did not investigate, but on 08/03/16 she talked with Staff B about lowering her voice when she talked to residents, because she sometimes sounded harsh or like she was yelling when communicating with residents.</p> <p>-She did not document her conversation with Staff B regarding the tone in her voice and how to communicate with the residents.</p> <p>-She did not think the incident regarding Staff B</p>	D 438		

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D 438	<p>Continued From page 70</p> <p>needed to be reported to the Health Care Personnel Registry.</p> <p>Interview on 08/25/16 at 2:55 pm with Resident #8 revealed: -She did not like how Staff B yelled at her, so she told the AA. -Staff B knew she was not afraid of her and she would speak up for herself.</p> <p>Interview on 08/30/16 at 9:30 am with the Resident Care Coordinator (RCC) revealed: -There was an incident with Resident #8 and Staff B. -One day last month (July 2016, can't recall specific date) she was in the hallway and heard Resident #8 screaming and yelling. -She went to the resident's room to find out what was happening. -The resident told her she was in pain, and Staff B said she had to get-up. -She offered the resident pain medication.</p> <p>Confidential interview with two staff revealed: -Initially, they were afraid to talk because the Administrator was near and were afraid of getting fired. -Both staff said, Staff C was not that bad, and they had not observed Staff C treating residents bad. -Both staff said, Staff B talked to residents "smart" mouth, yelled and argued with residents, and said harsh words with a sharp pitch to her voice. -They had not observed Staff B hit residents, but they were aware residents did not like the way Staff B treated them. -Both staff were sure the Administrator was aware of Staff B's attitude toward residents.</p>	D 438		

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D 449	Continued From page 71	D 449		
D 449	<p>10A NCAC 13F .1211 (b) Written Policies And Procedures</p> <p>10A NCAC 13F .1211Written Policies And Procedures</p> <p>(b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, record reviews, the facility failed to assure 5 of 7 sampled staff completed training in infection control within 30 days of hire on the policy and procedures of infection control (Staff A, B, C, D, and E).</p> <p>The findings are:</p> <p>A. Review of Staff A's personnel file revealed: -Staff A was hired on 10/6/14 as a cook. -No documentation Staff A had infection control training.</p> <p>Observation on 8/23/16 between 11:30 am and 12:30 pm revealed: -Staff A prepared the table setting for the residents. -Staff A poured beverages and plated food for the residents.</p> <p>-Observation on 8/25/16 between 8:00 and 10:00 am revealed Staff A cleaned residents' rooms,</p>	D 449		

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D 449	<p>Continued From page 72</p> <p>swept the floors, mopped, and dusted the furniture.</p> <p>Interview on 8/25/16 at 11:00 am with Staff A revealed:</p> <ul style="list-style-type: none"> <li>-He was hired as a cook and worked part time.</li> <li>-He worked part time in housekeeping too.</li> <li>-His duties included preparing meals for residents, setting the table before meals, cleaning the dining room area, as well as the kitchen.</li> <li>-His duties also included cleaning residents' rooms, sweeping moping, and dusting.</li> <li>-He cleaned the common areas and mopped the hallways.</li> <li>-He did not have infection control training, but gloves were available for him to use.</li> <li>-He said he used gloves when setting the tables, cooking, cleaning and plating the food for the residents.</li> </ul> <p>Refer to interview on 8/25/16 at 4:00 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to observation of the facility prevention infection control policy.</p> <p>Refer to interview on 8/25/16 at 9:00 am with the Administrator.</p> <p>B. Review of Staff B's personnel file revealed:</p> <ul style="list-style-type: none"> <li>-Staff B was hired on 10/15/15 as a Personal Care Aide (PCA).</li> <li>-No documentation Staff B had infection prevention control training</li> </ul> <p>Interview on 8/23/16 at 10:00 am with Staff B revealed her duties included personal care to residents, bathing, feeding, transfers, and dressing.</p>	D 449		

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D 449	<p>Continued From page 73</p> <p>Observation on 8/23/16 between 10:30 am and 11:45 am revealed:</p> <ul style="list-style-type: none"> <li>-Staff B assisted a resident to the room for personal care.</li> <li>-Staff B assisted a resident with transfer to the common area via wheel chair.</li> <li>-Staff B assisted residents to the dining room via wheel chair and walkers.</li> </ul> <p>Refer to interview on 8/25/16 at 4:00 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to observation of the facility prevention infection control policy.</p> <p>Refer to interview on 8/25/16 at 9:00 am with the Administrator.</p> <p>C. Review of Staff C's personnel file revealed:</p> <ul style="list-style-type: none"> <li>-Staff C was hired on 4/20/16 as a Personal Care Aide (PCA).</li> <li>-No documentation Staff C had infection control training.</li> </ul> <p>Attempted interview on 8/24/16 at 3:00 pm with Staff C was unsuccessful.</p> <p>Refer to interview on 8/25/16 at 4:00 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to observation of the facility prevention infection control policy.</p> <p>Refer to interview on 8/25/16 at 9:00 am with the Administrator.</p> <p>D. Review of Staff D's personnel file revealed:</p> <ul style="list-style-type: none"> <li>-Staff D was hired on 2/11/14 as a housekeeper.</li> <li>-No documentation Staff D had infection control training</li> </ul>	D 449		

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D 449	<p>Continued From page 74</p> <p>Observation on 8/23/16 between 10:00 am and 12:00 pm of Staff D revealed: -Staff D cleaned residents' rooms, dusted, swept and mopped the floors, cleaned the common bathroom, cleaned the common area, and mopped the hallways. -Staff D had worn gloves when cleaning the rooms, common areas, and bathrooms.</p> <p>Interview on 8/23/16 at 10:30 am with Staff D revealed: -The facility had not provided her with infection control training. -She was aware when to wear gloves and often doubled gloved when cleaning residents' restrooms. -The facility always had gloves to use when she cleaned.</p> <p>Refer to interview on 8/25/16 at 4:00 pm with the Resident Care Coordinator (RCC).</p> <p>Refer to observation of the facility prevention infection control policy.</p> <p>Refer to interview on 8/25/16 at 9:00 am with the Administrator.</p> <p>E. Review of Staff E's personnel file revealed: -Staff E was hired on 2/11/14 as a Personal Care Aide (PCA). -No documentation Staff E had infection control training.</p> <p>Attempted interview on 8/25/16 at 4:00 pm with Staff E was unsuccessful.</p> <p>Refer to interview on 8/25/16 at 4:00 pm with the Resident Care Coordinator (RCC).</p>	D 449		

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D 449	<p>Continued From page 75</p> <p>Refer to observation of the facility prevention infection control policy.</p> <p>Refer to interview on 8/25/16 at 9:00 am with the Administrator.</p> <p>_____</p> <p>Interview on 8/25/16 at 4:00 pm with the Resident Care Coordinator (RCC) revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for the clinical nursing staff.</li> <li>-She was unaware all staff were required to have infection control training.</li> <li>-She thought only MAs were required to have yearly infection control training.</li> <li>-She was unsure if all the staff had infection control training.</li> <li>-She kept the facility infection control policy in her office.</li> </ul> <p>Observation of the facility infection control policy revealed the policy included proper hand washing, gloves usage, and blood borne pathogen training.</p> <p>Interview on 8/25/16 at 9:00 am with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>-She was unaware all staff were required to complete infection control training upon hire.</li> <li>-She was aware the facility had a policy on infection control and the manual was kept in the RCC's office.</li> <li>-She had verbally instructed the cooks and housekeeping on gloves and hand washing techniques when they were hired.</li> <li>-She thought the RCC had verbally instructed the nursing staff on infection control upon hire.</li> <li>-She had no documentation of staff trained on infection control upon hire.</li> <li>-All staff would attend a mandatory infection</li> </ul>	D 449		

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D 449	Continued From page 76  control class scheduled for September 1, 2016.	D 449		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to free of hazards (bed bugs), sharing glucometers, and Health Care.</p> <p>The findings are:</p> <p>A. Based on observations, interviews, and record reviews the facility failed to maintain the facility in a clean and orderly manner free of obstructions and hazards in regards to bed bug infestation throughout the facility. [Refer to Tag D0079 10A NCAC 13F .0306(a)(5) Housekeeping and furnishings (Type B Violation).].</p> <p>B. Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs of 3 of 5 (Residents #1, and #2) regarding the need for continuous positive airway pressure (CPAP) therapy, Thrombo-Embolic Deterrent (TED) hose, and low blood pressures (BP). [Refer to Tag D273</p>	D912		

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D912	Continued From page 77  10A NCAC 13F .0902(b) Health Care Referral (Type B Violation).  C. Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucometers without disinfection of the glucometer and sharing lancing devices when used for different residents for 3 of 14 sampled residents (Residents #3, #10, and #11) with orders for fingerstick blood sugars (FSBS). [Refer to Tag D932 G. S. 131D4.4A(b) ACH Infection Prevention Requirements (Type B Violation).].	D912		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements  G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements  (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions.	D932		

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D932	<p>Continued From page 78</p> <p>e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.</p> <p>f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.</p> <p>(2) Require and monitor compliance with the facility's infection control policy.</p> <p>(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, record reviews and interviews, the facility failed to assure adequate and appropriate infection control procedures were implemented for blood glucose monitoring by sharing glucometers without disinfection of the glucometer and sharing lancing devices when used for different residents for 3 of 14 sampled residents (Residents #3, #10, and #11) with orders for fingerstick blood sugars (FSBS).</p> <p>The findings are:</p> <p>Observation on 08/23/16 at 12:00 pm of facility glucometer use revealed: -A Medication Aide (MA) was performing the FSBSs in the medication room.</p>	D932		

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NAME OF PROVIDER OR SUPPLIER  <b>ST GALES ESTATES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405</b>
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D932	<p>Continued From page 79</p> <ul style="list-style-type: none"> <li>-The MA opened a plastic case labeled with Resident #3's name.</li> <li>-A glucometer was labeled with another resident's name.</li> <li>-An unloaded lancing pen was labeled with Resident #3's name.</li> <li>-The MA loaded and used the lancing pen to obtain the FSBS for Resident #3.</li> <li>-The MA opened an unlabeled glucometer case which was laying on the counter and used the unlabeled Brand A glucometer to obtain Resident #3's FSBS result.</li> <li>-The MA used an alcohol saturated cotton ball to wipe the glucometer before use.</li> </ul> <p>Observation on 08/23/16 at 12:15 pm of the facility glucometer use revealed:</p> <ul style="list-style-type: none"> <li>-The MA opened the plastic case labeled with Resident's #10's name.</li> <li>-The plastic case did not contain a glucometer.</li> <li>-An unloaded lancing pen was labeled with Resident #10's name.</li> <li>-The MA loaded and used the lancing pen to obtain the FSBS for Resident #10.</li> <li>-The MA used an alcohol saturated cotton ball to wipe the glucometer before use.</li> <li>-The MA used the unlabeled Brand A glucometer from the counter to obtain the Resident #10's FSBS result.</li> <li>-This was the same glucometer that was previously used to obtain Resident #3's FSBS.</li> </ul> <p>Observation on 08/23/16 at 12:18 pm of facility glucometer use revealed:</p> <ul style="list-style-type: none"> <li>-The MA opened the plastic case labeled with Resident's #11's name.</li> <li>-The plastic case contained a glucometer labeled with another resident's name..</li> <li>-An unloaded lancing pen was labeled with Resident #11's name.</li> </ul>	D932		

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D932	<p>Continued From page 80</p> <ul style="list-style-type: none"> <li>-The MA loaded and used the lancing pen to obtain the FSBS for Resident #11.</li> <li>-The MA used an alcohol saturated cotton ball to wipe the glucometer before use.</li> <li>-The MA used the unlabeled Brand A glucometer from the counter to obtain the Resident #11's FSBS result.</li> <li>-This was the same glucometer that was previously used to obtain Resident #3 and Resident #11's FSBS.</li> </ul> <p>Interview on 08/23/16 at 12:20 with the MA revealed:</p> <ul style="list-style-type: none"> <li>-"This is the glucometer we use for everybody".</li> <li>-"We ran out of strips" for residents because the diabetic supply company no longer provided diabetic supplies to this part of the state.</li> <li>-"We had to get a new company, and all that paperwork is being processed right now."</li> <li>-"This glucometer has been used by all the diabetic residents for about 2 months".</li> </ul> <p>Observation on 08/23/16 at 1:00 pm of the medication room where the diabetic supplies were stored revealed:</p> <ul style="list-style-type: none"> <li>-21 plastic cases labeled with residents' names.</li> <li>-6 of 21 plastic cases contained labeled glucometers which matched the resident's name labeled on the plastic case.</li> <li>-4 of 21 plastic cases contained labeled glucometers which did not match the name labeled on the plastic cases.</li> <li>-1 plastic case contained a labeled glucometer which matched the name on the case and another labeled glucometer which belonged in another case.</li> <li>-1 plastic case contained an unlabeled glucometer.</li> <li>-9 of 21 plastic cases contained no glucometers, labeled or unlabeled.</li> </ul>	D932		

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D932	<p>Continued From page 81</p> <p>Further observation on 08/23/16 from 1:00 pm to 1:30 pm of the 21 labeled plastic cases revealed:</p> <ul style="list-style-type: none"> <li>-There was a total of 22 lancing pens in the plastic cases.</li> <li>-None of the lancing pens was loaded with a lancing device.</li> <li>-Each of the lancing pens were empty.</li> <li>-11 of 21 plastic cases contained labeled lancing pens matched the name labeled on the plastic cases.</li> <li>-7 of 21 plastic cases contained unlabeled lancing pens,</li> <li>-1 plastic case contained a labeled lancing pen which belonged in another case.</li> <li>-1 plastic case contained a lancing pen labeled as "Extra".</li> <li>-1 plastic case contained a labeled lancing pen which matched the name labeled on the plastic case and had another labeled lancing pen which belonged in another case.</li> <li>-1 plastic case contained no lancing pen.</li> </ul> <p>Interview on 8/23/16 at 1:00 pm with a representative from the glucometer manufacturer:</p> <ul style="list-style-type: none"> <li>-The Brand A glucometer used by the facility was for single use by one resident.</li> <li>-The manufacturer sent the facility an Brand A glucometer for each resident.</li> <li>-Cleaning instructions were to wipe down with a dry towel, do not use bleach.</li> <li>-If the glucometer is used for multiple residents it must be disinfected between each use.</li> <li>-The manufacturer recommended disinfectant wipes (wrap glucometer with wipe and wait 3-5 minutes for disinfecting) after each use if shared with multiple residents.</li> <li>-The manufacturer referred to the web site and instruction manual distributed to the facility with each glucometer.</li> </ul>	D932		

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D932	<p>Continued From page 82</p> <p>Interview on 08/23/16 at 2:10 pm with the Resident Care Coordinator (RCC) revealed: -She called the diabetic supply company around the 4th of July to order supplies (glucometer strips). -She was told the company can no longer provide the diabetic supplies, and she was advised to call Medicaid. -She called Medicaid and was told that nothing can be done, the funds are gone. -Each diabetic resident's family had been notified to see if they could provide the strips needed for the glucometers, none had responded with supplies. -The pharmacy used by the facility provided oversight to the facility, and the pharmacy representative stated the glucometer could be used by multiple residents if it was cleaned with alcohol between each use. -"I had no idea we were doing anything wrong, because the pharmacy said we could do it this way".</p> <p>Interview on 08/23/16 at 2:15 pm with the Administrator revealed: -She was aware of the problems with the diabetic supply company and the facility was actively seeking a solution. -She was aware that glucometers should not be shared between residents, but thought that a temporary solution had been found, based on the pharmacy recommendation to clean the shared glucometer with alcohol between each use.</p> <p>Interview on 08/23/16 at 5:45 pm with a second MA revealed: -The supply company stopped sending strips for the glucometers, so the facility ran out. -That's when the facility started using the shared</p>	D932		

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D932	<p>Continued From page 83</p> <p>glucometer for all the diabetics, "a while ago". -The shared glucometer was cleaned with alcohol between each use.</p> <p>Confidential interview with a resident on 08/24/16 at 4:45 pm revealed: -"They use that little machine to check my sugar". -The resident would not recognize her glucometer.</p> <p>Confidential interview with a resident on 08/24/16 at 5:10 pm revealed: -"They take care of all that when they check my sugar". -"I guess they use my glucometer".</p> <p>_____</p> <p>The facility provided a Plan of Protection on 08/23/16 which included: -The facility discarded the house glucometers (there were 2, only 1 of which was observed to be used). -Each resident has their own labeled glucometer and lancing pen, located in their labeled case. -Administrator will purchase germicidal wipes on 08/24/16. -RCC will educate all MAs on infection control for device cleaning and glucometer and lancet use on 08/23/16. -All MAs will complete infection control training with a Registered Nurse within 2 weeks. -Glucometers and lancing pens will be checked daily by the RCC for one week, and will continue to be monitored monthly.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 15, 2016.</p>	D932		

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D934	Continued From page 84	D934		
D934	<p>G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure annual in-service training for infection control was completed for 1 of 2 sampled Medication Aides (Staff F).</p> <p>The findings are:</p> <p>Review of Staff F's personnel record revealed: -A hire date of 12/3/14 and hired as a Personal Care Aide (PCA). -A change in employment status from a PCA to a Medication Aide (MA) on 2/3/15. -Documentation of a passing score on the written Medication Aide test on 10/23/2000. -Documentation of completion of the 15 hours Medication Aide training on 1/5/16. -There was no documentation of a certificate of completion of annual infection control training.</p>	D934		

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D934	<p>Continued From page 85</p> <p>Interview on 8/24/16 at 4: 00 pm with Staff F revealed: -She was hired as a PCA and then started working as a MA. -She could not recall any infection control training provided by the facility. -A nurse came to the facility and taught an infection control training class in May 2016, but she could not attend.</p> <p>Interview on 8/25/16 at 9:00 am with the Administrator revealed: -She was aware the MAs were required to complete the annual state approved infection control training. -She was unsure why Staff F had not attended the infection control training class in May 2016. -Staff F would attend the state approved infection control class conducted by a Register Nurse scheduled for September 1, 2016.</p>	D934		