

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025031 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 08/17/2016 |
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NAME OF PROVIDER OR SUPPLIER
RIVERVIEW

STREET ADDRESS, CITY, STATE, ZIP CODE
**3407 OAK ROAD
NEW BERN, NC 28563**

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| D 000 | Initial Comments The Adult Care Licensure Section and the Craven County Department of Social Services conducted an annual survey and complaint investigation on August 15-17, 2016. The complaint investigation was initiated by the Craven County Department of Social Services on 7/1/2016. | D 000 | | |
| D 074 | <p>10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations and interviews, the facility failed to assure the walls, ceilings, baseboards, doors and floor coverings in the lobby, hallways, resident rooms and common-use bathrooms were kept clean and in good repair.</p> <p>The findings are:</p> <p>Observations of the facility's lobby on 8/16/16 at 10:10am revealed the air conditioner wall unit was leaking into two pink buckets which were overflowing creating a 20-foot wide puddle of water on the floor.</p> <p>Observations of the women's bathroom in the lobby on 8/16/16 at 10:10am revealed: -There was mold on the bathroom wall tiles behind the sink and toilet. -The paper towel dispenser was rusted.</p> | D 074 | <p>The facility has hired a construction company to come in and assure the walls, ceilings, baseboards, doors and floor coverings in the lobby, hallways, resident rooms and common-use bathrooms are kept in good repair.</p> <p>Based on observations in all identified rooms, bathrooms and common areas the facility will replace any and all light bulbs.</p> | 10/31/16 |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Maria J. Sinclair, Administrator

TITLE

(X6) DATE

9/26/16

If continuation sheet 1 of 91

Accepted & Reviewed:
10/6/2016

Christopher Clark, R.N., M.S.W.

Christopher Clark Facility



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| D 074 | <p>Continued From page 2</p> <ul style="list-style-type: none"> -The floors were covered with many dirt particles and numerous pieces of loose toilet paper. -There were numerous black hair follicles in 2 of the 3 sinks. -The light switch knob was missing. <p>Observations of the women's common use bathroom to the right of room #2 on 8/16/16 at 10:34 am revealed:</p> <ul style="list-style-type: none"> -There were 2 rusted faucets that were corroded. -There was a shower curtain rod with rings and no shower curtain. -The floors were covered with many dirt particles and numerous pieces of loose toilet paper. <p>Observation of resident room #3 on 8/16/16 at 10:35am revealed the drywall between the two closets was patched and unpainted.</p> <p>Observation of resident room #4 on 8/16/16 at 10:38 am revealed the door and door frame had several unpainted sections.</p> <p>Observation of resident room #6 on 8/16/16 at 10:47 am revealed both closet doors and door frames were patched and unpainted.</p> <p>Observation of resident room #7 on 8/16/16 at 10:48 am revealed:</p> <ul style="list-style-type: none"> -The right wall was patched and unpainted. -The door frame had peeling paint and unpainted areas. -The light switch plate was rusted. <p>Observation of the men's shower to the right of room #7 on 8/16/16 at 10:54am revealed:</p> <ul style="list-style-type: none"> -The wood around the door latch mechanism was rotted. -The wall had peeling paint by the thermostat. -The fluorescent light ceiling fixtures had no bulb | D 074 | <p>Staff on proper cleaning procedures to ensure all walls, tile, sinks, toilets, residents rooms, common areas, hallways, bathrooms, and lobbies are cleaned properly. The compliance officer and housekeeper staff will complete daily and weekly 10/31/16 checks to ensure that all areas identified are maintained clean and in proper working condition. This process will also be monitored by daily walkthrough of facility manager and weekly Q.A. meetings by the Administrator.</p> | |

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| D 074 | <p>Continued From page 3</p> <p>cover.</p> <ul style="list-style-type: none"> -The pipes leading to the toilet were rusted. -The wall around the toilet paper dispenser was unpainted. -The handheld shower faucet was rusted. -There were two active wasp nests above the bathroom window. -The grout along the entire bathroom border was broken. -The door frame was rusted from the floor to 2-feet above the floor. -The door had pitting rust spots on the outside of the door. <p>Observation of the water cooler in the hallway to the right of the men's shower on 8/16/16 at 10:57 am revealed a folded rust-stained hospital blanket underneath saturated with water which extended 2-feet beyond the blanket on the floor.</p> <p>Observation of resident room #8 on 8/16/16 at 11:07 am revealed:</p> <ul style="list-style-type: none"> -The door was stuck and had to be forced open. -The light switch had grime buildup. -The left wall had multiple large drywall scratches. -The window had a 4-inch by 2-inch hole covered by blue masking tape. -There was a 1-inch diameter hole in the right wall under the mirror. -There was grime on the picture frames. <p>Observation of resident room #9 on 8/16/16 at 11:10am revealed:</p> <ul style="list-style-type: none"> -The left closet door needed paint. -The air-conditioner unit was not situated correctly creating a 10-inch long vertical gap in the upper right corner to the outside. <p>Observation of resident room #10 on 8/16/16 at 11:16am revealed:</p> | D 074 | | |

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| D 074 | <p>Continued From page 4</p> <ul style="list-style-type: none"> -The door had a large brown stain at the base. -There was an 8-inch cobweb in the left upper ceiling corner by the window. -There was a missing closet door knob. <p>Observations of the hallway between room #10 and #11 on 8/16/16 at 11:17 am revealed a partially detached 8-inch by 4-inch metal vent on the wall approximately two feet from the floor.</p> <p>Observation of resident room #11 on 8/16/16 at 11:18 am revealed:</p> <ul style="list-style-type: none"> -There was a partially unpainted light switch cover. -The ceiling paint was bubbled and peeling. -The left closet door had multiple unpainted areas. -There was paper clutter in the left closet. -There was mold over the top of the working air-conditioner vent and on the controls. -The right wall baseboard was missing. <p>Observation of resident room #12 on 8/16/16 at 11:21 am revealed:</p> <ul style="list-style-type: none"> -The floor had multiple particles of dirt in all areas of the room. -The base of the aluminum window had corrosion and would not close leaving a 1-inch gap to the outside. -Both closet doors had several unpainted areas. <p>Observation of resident room #13 on 8/16/16 at 11:24 am revealed:</p> <ul style="list-style-type: none"> -The 8-foot tall metal door frame had rust spots throughout the entire border. -The electrical wall plate on the right wall was detached. <p>Observation of resident room #14 on 8/16/16 at 11:26 am revealed:</p> | D 074 | | |

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| D 074 | <p>Continued From page 5</p> <ul style="list-style-type: none"> -Both closet doors had peeling paint and unpainted areas. -All four walls had patched unpainted areas. -There were multiple ceiling stains. -The ceiling paint was peeling. -There was a large red stain above the dresser on the wall. <p>Observation of resident room #15 on 8/16/16 at 11:28 am revealed:</p> <ul style="list-style-type: none"> -The door and both closet doors had large unpainted areas and scratches. -There were multiple scrapes on the drywall on all 4 walls. -The paint on the ceiling was peeling. -The baseboards were detached on all four walls. -There was rust-colored bubbling paint on the right wall. -There was a wood laminate table that was chipped and worn along all edges. <p>Observation of resident room #17 on 8/16/16 at 11:4am revealed:</p> <ul style="list-style-type: none"> -The door was misaligned and could not be closed without force. -The baseboards on all four walls were detached and had paint splotches. <p>Observation of the men's bathroom to the right of room #17 on 8/16/16 at 11:50am revealed:</p> <ul style="list-style-type: none"> -All four walls had peeling paint. -There was a 1-foot by 2-foot metal plate partially detached from the right side of the bath tub. -The light switches and thermostat were covered in grime. -The 2-foot long wood railing by the toilet had peeling paint. <p>Observation of room #19 on 8/16/16 at 2:29 pm revealed that the window blinds were yellowed</p> | D 074 | | |

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| D 074 | <p>Continued From page 6 and covered with dust.</p> <p>Observation of room #20 on 8/16/16 at 2:31 pm revealed: -There was no air conditioner. -The mirror was rusted. -There was a section of cardboard that was placed over the window opening where glass had broken out. -The light fixture did not work. -The baseboards on all four walls were detached. -The ceiling had peeling paint. -There were multiple holes in all 4 walls. -The top of the wall outlet had scorch marks.</p> <p>Observation of room #21 on 8/16/16 at 2:35pm revealed: -There was a 25-foot television cable not affixed to the wall. -The baseboards were detached on all four walls. -The window blinds had 2 broken slats. -The left closet's shelf was missing.</p> <p>Observation of room #22 on 8/16/16 at 2:38pm revealed: -All four walls had unpainted patched areas of drywall at the base, center and top of the walls. -There was mold on the air conditioner unit and on the control knobs.</p> <p>Observation of room #23 on 8/16/16 at 2:41 pm revealed all four walls had unpainted patched areas.</p> <p>Observation of room #24 on 8/16/16 at 2:43pm revealed: -All four walls had unpainted patched areas of drywall at the base, center and top of the walls. -The floors were covered with dead bugs and dust.</p> | D 074 | <p>The facility has hired a construction company that will be repairing all identified broken light fixtures, broken windows detached baseboards, rusted light covers, rusted paper towel dispensers and holes in the walls. This process will be monitored by the Administrator and Compliance officer to ensure that the identified areas have been corrected and maintained in a clean and safe manner. These areas would be further reviewed weekly at the Quality Assurance meeting.</p> | 10/31/16 |

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| D 074 | <p>Continued From page 7</p> <ul style="list-style-type: none"> -There was a 6-foot ceiling crack. -There was a broken clothes rack in the closet. <p>Observation of room #25 on 8/16/16 at 2:46 pm revealed the baseboards were detached on all four walls.</p> <p>Observation of room #26 on 8/16/16 at 2:48pm revealed:</p> <ul style="list-style-type: none"> -The window was not able to seal shut. -The baseboards on all walls were detached. -The air-conditioner unit was on the floor in front of the window. -There was a stained mattress box spring leaning against the wall. <p>Observation of room #27 on 8/16/16 at 2:49 pm revealed there was used stained absorbent cotton pad on a wheelchair by the window.</p> <p>Observation of the area by the patio exit door to the right of room #27 on 8/16/16 at 2:52pm revealed:</p> <ul style="list-style-type: none"> -The window blinds by the patio door were broken. -There were several spider webs by the patio door in the upper corners. -A 2-foot square section of the door was unpainted. -The was a bent section of sharp brown sheet metal roofing that protruded towards the residents when they exited the patio door on the left, approximately 5-feet above the ground when entering the smoking area. <p>Observation of room #28 on 8/16/16 at 2:56 pm revealed that all baseboards on all four walls was detached.</p> <p>Observation of room #29 on 8/16/16 at 2:57 pm</p> | D 074 | | |

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| D 074 | <p>Continued From page 8</p> <p>revealed:</p> <ul style="list-style-type: none"> -The door had several unpainted areas. -There were paint stains on the floor throughout the room. <p>Observation of room #31 on 8/16/16 at 3:02 pm revealed there was an active water leak by the ceiling light fixture.</p> <p>Observation of the Linen Room on 8/16/16 at 3:10pm revealed:</p> <ul style="list-style-type: none"> -There was a 10-inch crack in the ceiling. -All 4 walls had unpainted several patched areas of drywall at the base, center and top of the walls. -The light switch had grime. -There were 4 used plastic gloves discarded on the floor. <p>Observation of the emergency exit door area by the laundry room on 8/16/16 at 3:12pm revealed:</p> <ul style="list-style-type: none"> -The entire door frame was rusted with several unpainted areas. -The door was difficult to open and close without force. -There was a dead flattened frog on the door caught between the door and the frame on the upper left corner. -There were 6 wasp nests directly outside of the exit door with several wasps that flew into motion when the door was open. -There were 7 electrical box panels on the wall with unpainted areas around each panel border. <p>Observation of the assisted living side dining room on 8/16/16 at 3:19 pm revealed:</p> <ul style="list-style-type: none"> -All 4 walls had unpainted several patched areas of drywall at the base, center and top of the walls. -There was a 1-foot diameter area with an unknown sticky substance at the base of the soda vending machine. | D 074 | | |

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| D 074 | <p>Continued From page 9</p> <ul style="list-style-type: none"> -There was spackling over the exit sign over the door that had flaked off. -There was a 10-foot by 4-foot area of the ceiling that was stained. -All four walls had detached baseboard moldings. <p>Observation of the Special Care Unit (SCU) hallway on 8/16/16 at 3:28 pm revealed there were 26 railings with chipped paint.</p> <p>Observation of the SCU main door on 8/16/16 at 3:28 pm revealed had peeling paint, did not close easily and required a manual push to ensure closure,</p> <p>Observation of the SCU Resident Care Coordinator's office on 8/16/16 at 3:29 pm revealed the ceiling paint was peeling.</p> <p>Observation of the SCU Linen Room on 8/16/16 at 3:32pm revealed that all four walls had unpainted patched areas.</p> <p>Observation of resident room #34 on 8/16/16 at 3:34pm revealed the light switch cover plate was cracked.</p> <p>Observation of resident room #38 on 8/16/16 at 3:49 pm revealed that the baseboards on all four walls was detached.</p> <p>Observation of the SCU dining room on 8/16/16 at 3:52pm revealed:</p> <ul style="list-style-type: none"> -The light switch plate had grime. -The ceilings had a heavy coating of dust. <p>Interview with Housekeeping Supervisor on 8/16/16 at 10:26 am revealed:</p> <ul style="list-style-type: none"> -There were only two staff responsible for cleaning the entire facility, one for the assisted | D 074 | | |

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| D 074 | <p>Continued From page 10</p> <p>living side and one for the SCU side. -The staff worked until 3pm daily. -Maintenance was responsible for repairs of floors, walls, ceilings, electrical and broken furniture.</p> <p>Interview with Maintenance Supervisor on 8/16/16 at 10:42 am revealed: -He was not aware of anything needing repair. -He had no response when asked about current condition of the walls, baseboards, floors and ceilings. -He only fixed things that the "aides" told him to fix. -No one had told him that anything was in current need of repair.</p> | D 074 | | |
| | <p>-There was no written or verbal maintenance schedule. -He did not walk-thru the facility to identify areas in need of repair.</p> <p>Review of the most recent health department's building inspection revealed: -The report was dated 4/15/16. -There was an observation of and repeat corrective action report citing the baseboards throughout the facility needed to be replaced. -There was an observation of and repeat corrective action report citing numerous rooms with personal clothing on the floor and on closet floors. -There was an observation of and repeat corrective action report citing the cleanliness of the men's bathroom floors and toilets which were observed with vomit and urine pools underneath the commodes and sinks.</p> <p>Confidential interviews with 5 staff revealed: -The owner did not want to put money into repairing the building.</p> | | | |

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| D 074 | <p>Continued From page 11</p> <ul style="list-style-type: none"> -The baseboards and floors were stained and unable to be cleaned. -The baseboards had not been replaced in any of the rooms. -The dry wall holes are patched by maintenance but never repainted. -There were too many items to repair for the one maintenance person to perform. -The facility doors, walls, baseboards and ceiling issues have been the same for several years. -The facility kept getting cited for the same violations but only repaired what they absolutely had to repair. <p>Interview with the Administrator on 8/16/16 at 2:45pm-revealed:</p> <ul style="list-style-type: none"> -The facility had made a lot of improvements since last year, none of which he could specifically identify. -He was aware that "a few" of the floors, ceilings, walls and baseboards needed repairs. -There were no time limits for completion of repairs nor schedule of current ongoing repairs. <p>Interview with the Owner on 8/17/16 at 10:15am revealed:</p> <ul style="list-style-type: none"> -The facility would identify all areas of repair need as related to floors, baseboards, ceilings and walls. -He walked through the facility monthly and was unaware of the condition of the floors, baseboards, ceilings and walls. -He acknowledged that some of the holes in the walls of resident rooms had been repaired. -He would "hire a crew to complete all of the needed repairs today if he knew what they needed to fix." -He would inspect all rooms with the Administrator and Facility Manager to identify needed repairs. | D 074 | | |

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NAME OF PROVIDER OR SUPPLIER
RIVERVIEW

STREET ADDRESS, CITY, STATE, ZIP CODE
**3407 OAK ROAD
NEW BERN, NC 28563**

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| D 074 | <p>Continued From page 12</p> <p>-He was unaware that the condition of the floors, walls, ceilings and baseboards were out of compliance.</p> <p>-He was unaware that the building inspector identified many of the same issues with the baseboards, floors, ceilings and walls on the report dated 4/15/16.</p> <p>Review of the facility's Plan of Protection dated 8/17/16 revealed:</p> <p>-The Administrator and Facility Manager will inspect all resident rooms for issues with floors, ceiling, baseboards and walls to address any areas in need of repair.</p> <p>-Any dangerous areas will be immediately addressed.</p> | D 074 | | |
| D 076 | <p>-All repair needs related to floors, ceilings, baseboards and walls will be reported by the Maintenance Director to the Administrator.</p> <p>-The Administrator and Facility Manager will meet weekly with housekeeping, maintenance and kitchen leaders to discuss any repair needs or issues requiring attention.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2016.</p> <p>10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(a) Adult care homes shall:</p> <p>(3) have furniture clean and in good repair;</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by:</p> | D 076 | | |

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| D 076 | <p>Continued From page 13</p> <p>Based on observations and interviews, the facility failed to assure the furniture was kept clean and in good repair.</p> <p>The findings are:</p> <p>Observations of resident room #3 on 8/16/16 at 10:35am revealed a grime-covered dresser with 3 missing drawer handles.</p> <p>Observations of resident room #14 on 8/16/16 at 11:26am revealed a dresser with a white sticky substance on 3 of 12 drawer handles.</p> <p>Observations of unoccupied resident room #16 on 8/16/16 at 11:45am revealed a mattress covered with mold.</p> <p>Observations of resident room #20 on 8/16/16 at 11:26am revealed a rusted mirror with a half-inch round hole on the left side of the frame.</p> <p>Observations of resident room #21 on 8/16/16 at 2:35pm revealed a dresser with a white sticky substance on 2 of the 12 drawer handles.</p> <p>Observations of resident room #22 on 8/16/16 at 2:35pm revealed a dresser with 2 of 14 broken handles.</p> <p>Observations of resident room #23 on 8/16/16 at 2:41pm revealed a grey plastic chair covered in grime.</p> <p>Observations of resident room #29 on 8/16/16 at 2:57pm revealed a stained plastic mattress.</p> <p>Observations of resident room #30 on 8/16/16 at 2:59pm revealed multiple white paint splotches on top of the dresser.</p> | D 076 | <p>The facility owner has purchased new furniture to replace all identified furniture that needed to be replaced. This furniture includes mattresses, box springs, dressers, night stands, chairs and lamps.</p> <p>The facility has also trained and inserviced all housekeeping staff on the proper cleaning procedures to ensure that all furnishings identified as needing to be cleaned, will be free from mold, mildew, grime, stains, rust and any type residue that would make it unclean.</p> <p>This process will be checked and addressed</p> | 10/31/16 |

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| D 076 | Continued From page 14 Observations of resident room #34 on 8/16/16 at 3:34pm revealed white paint splotches on the upper left front of the dresser. Observations of resident room #39 on 8/16/16 at 3:53pm revealed the footboard of the bed was heavily scratched and had several unpainted areas. Observations of the TV lounge on 8/16/16 at 4:05pm revealed: -There were 3 vinyl-covered chairs with white paint splotches on the armrests and torn edges. -There was a 48-inch round white laminate table with a sharp brown-colored border where the laminate had worn away. -There was a 48-inch round wood veneer table that was sticky and dirty with flaking varnish. Confidential interviews with 10 residents revealed: -The maintenance man does not cover furniture when he paints things. -The tables in the TV room were old and the chairs were torn. -The residents "made due" with broken handles because the facility would not repair them. -The residents felt fortunate to have a dresser even if it was broken or had no handles. -The residents did not feel comfortable asking the Facility Director for furniture repairs because of the her historical lack of response. -The residents checked outdoor chairs and benches for ants and wasp nests before sitting down as many residents at the facility had been bitten or stung. -The furniture condition was the least of the facility's problems. -The furniture was in the present condition for a | D 076 | by the Administrator and Compliance officer to ensure that all furnishings are clean and in good repair. This area will also be monitored during the weekly Q.A. meetings and issues report to the owner. | 10/31/16 |

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| D 076 | <p>Continued From page 15</p> <p>minimum of five years.</p> <p>Interview with the Maintenance Director on 8/16/16 at 2:42pm revealed: -He only repairs items that the manager of the facility tells him about. -He did not observe any repair or maintenance issues with the table, chairs or benches. -He did not receive any repair or maintenance requests for any tables, chairs or benches. -If there were any ants or wasps on any furniture, he would vacuum them with the shop vac. -He had no comment about the paint or sticky surfaces on the dressers or chairs. -He shrugged and gave no answer when asked if he did a walk through the facility on a regular basis to identify things that needed to be fixed or replaced.</p> <p>Interview with the Administrator on 8/16/16 at 2:45pm revealed: -He was unaware that some of the dressers and chairs had missing handles and paint splatter. -He had not seen any dirty, damaged or sticky furniture at the facility. -The facility did not have a to-do list for furniture needing repair. -If something needed repair, the facility staff, Facility Director or the Administrator would talk to the Maintenance Director who would fix the issue. -The facility had a pest control company to address ants and wasps that may crawl around any furniture in the facility.</p> <p>Interview with the Owner on 8/17/16 at 10:15am revealed: -He was unaware of any furniture needing repair or replacement. -He walked through the facility at least once per month and had not noticed any problems with</p> | D 076 | | |

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| D 076 | Continued From page 16 chairs, furniture, dressers or tables. -His expectation was that the staff identify and fix or repair any furniture needing attention. -No residents or staff had informed him of any furniture needing repairs. | 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; | D 079 | <p>The facility has contracted with a pest control operator who makes monthly visits. These monthly visits include the management of bed bugs, roaches, crickets, ants, spiders, wasps, gnats and any other pests. The facility will identify and inspect all identified areas of the facility and have these areas treated weekly until these areas can be taken care of, at which time the monthly routine service will resume. This service will be performed on every room in the facility.</p> | |
| | <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations and interviews, the facility failed to assure the home was maintained clean and free of all obstructions and hazards in residents' rooms and hallways as related to bed bugs, roaches, crickets, ants, wasps, and gnats.</p> <p>The findings are:</p> <p>Observations of the unoccupied model bedroom, room #1 on 8/16/16 at 10:20am revealed:</p> <ul style="list-style-type: none"> -There was a live roach on top of a large cardboard box in the middle of the room. -There were 4 spiders in each of the 4 ceiling corners of the room. -The ceiling light fixture globe contained numerous dead bugs. | | | |

Addendum: Type B violation exceeds maximum correction date. Spoke with Administrator on 10/6/16. Actual correction date is: 10/1/16.

[Handwritten Signature]

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| D 079 | <p>Continued From page 17</p> <p>Observation of resident room #2 on 8/16/16 at 10:23am revealed: -There was a live wasp under the bedside portable commode. -There were numerous dead gnats on the right side of the window ledge.</p> <p>Observation of resident room #3 on 8/16/16 at 10:35am revealed: -The glass ceiling light fixture globe contained numerous dead bugs. -There were several unknown dead bugs along the entire lengths of 3 of the 4 walls.</p> | D 079 | <p>In addition the facility compliance officer is completing daily bed bug and pests checks. These checks are documented and reviewed by the facility manager and administrator weekly. The compliance officer is also doing daily ground checks to ensure that</p> | |
| | <p>Observation of resident room #4 on 8/16/16 at 10:38am revealed that the ceiling light fixture globe contained numerous dead bugs.</p> <p>Observation of resident room #6 on 8/16/16 at 10:47am revealed the top of the air-conditioner frame was covered in dead gnats and roaches.</p> <p>Observation of resident room #7 on 8/16/16 at 10:48am revealed that the window ledge was covered in dead gnats.</p> <p>Observation of resident room #8 on 8/16/16 at 11:07am revealed several dead roaches and gnats on the floor and window sill.</p> <p>Observation of resident room #9 on 8/16/16 at 11:10am revealed there were numerous dead bugs in the ceiling light fixture.</p> <p>Observation of resident room #10 on 8/16/16 at 11:16am revealed: -There were numerous dead bugs in the ceiling light fixture globe. -There were numerous dead bugs on the sill of</p> | | <p>any dirt piles and wasp nest that could potentially be harmful to residents, visitors or staff. The house keeping staff have been trained and inserviced on the proper cleaning procedures to ensure that residents rooms and hallways are obstruction and clutter-free and free of all hazards of identified bugs. The facility manager, administrator will monitor this daily weekly.</p> | <p>10/31/16 10/2/16 see ADD 1004</p> |

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| D 079 | Continued From page 18 the air conditioner. -There were numerous bugs, both dead and alive on window ledge. Observation of resident rooms #12 on 8/16/16 at 11:21am revealed: -There was a 2-inch long roach on the floor by the air-conditioner. -There were several gnats on the window sill. Observations of resident room #13 on 8/16/16 at 11:24am revealed: -There were various bugs on the window sill and on top of the air conditioner vent. -There were 2 large dead roaches and a dead cricket by the door entry. -There were numerous dead bugs in the ceiling light fixture globe. Observation of room #15 on 8/16/16 at 11:28am revealed: -There were numerous dead bugs in the ceiling light fixture globe. -There were 10 dead bugs along the left wall. -There were over 100 dead bugs at the base of the air conditioner. -There were multiple dead roaches, crickets and ants along the baseboards. -There were 3 live spiders in the left ceiling corner above the window. -There was a live spider in the far right ceiling corner. Observation of resident room #17 on 8/16/16 at 11:44am revealed: -There were several dead bugs on the window sill. -There were live ants on the window sill. -There were multiple dead bugs on top of the air-conditioner. | D 079 | | | |

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| D 079 | <p>Continued From page 19</p> <p>Observation of room #19 on 8/16/16 at 2:29pm revealed that there were dead bugs on top of the air conditioner unit.</p> <p>Observation of room #20 on 8/16/16 at 2:31pm revealed there were numerous dead bugs on the window sill.</p> <p>Observation of room #21 on 8/16/16 at 2:35pm revealed there were live ants crawling on the ledge.</p> <p>Observation of room #22 on 8/16/16 at 2:38pm revealed there were several bugs dead and alive along the baseboards.</p> <p>Observation of room #23 on 8/16/16 at 2:41pm revealed there were bugs on top of the air conditioner frame, along the window sill and in the ceiling light fixture globe.</p> <p>Observation of room #24 on 8/16/16 at 2:43pm revealed: -There were bugs on top of the air conditioner frame, along the window sill and in the ceiling light fixture globe. -There was a large dead cricket on the floor by the door.</p> <p>Observation of room #25 on 8/16/16 at 2:46pm revealed there were bugs on top of the air conditioner frame, along the window sill and in the ceiling light fixture globe.</p> <p>Observation of room #26 on 8/16/16 at 2:48pm revealed there were bugs on top of the air conditioner frame, along the window sill and in the ceiling light fixture globe.</p> | D 079 | | |

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| D 079 | <p>Continued From page 20</p> <p>Observation of room #27 on 8/16/16 at 2:49pm revealed there were multiple dead bugs on the window sill.</p> <p>Observation of room #28 on 8/16/16 at 2:56pm revealed there were numerous dead bugs in the ceiling light fixture globe, on the window sill and several dead crickets on the floor.</p> <p>Observation of room #29 on 8/16/16 at 2:57pm revealed there were numerous dead bugs in the ceiling light fixture globe and on the window sill.</p> <p>Observation of room #30 on 8/16/16 at 2:57pm revealed there were several dead bugs on the window sill and along all 4 baseboards.</p> | D 079 | | |
| | <p>Observation of the assisted living side dining room on 8/16/16 at 3:19pm revealed:</p> <ul style="list-style-type: none"> -There were several dead bugs on four of the window sills. -There was a 4-inch wide mound of black dust beneath the electrical outlet on the far left wall with ants going in and out of the cover plate. -There were 8 live roaches on the floor. -There were spiders in each ceiling corner. <p>Observation of the SCU Resident Care Coordinator's office on 8/16/16 at 3:29pm revealed there were several dead bugs on the window sills.</p> <p>Observation of resident room #36 on 8/16/16 at 3:45pm revealed:</p> <ul style="list-style-type: none"> -There were numerous dead bugs in the ceiling light fixture globe. -There were several live baby roaches on the window ledge. -There were several dead bugs on top of the air conditioner. | | | |

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| D 079 | <p>Continued From page 21</p> <p>Observation of resident room #37 on 8/16/16 at 3:47pm revealed: -There were numerous dead bugs in the ceiling light fixture globe. -There were live and dead bugs on the floor including roaches and ants.</p> <p>Observation of resident room #38 on 8/16/16 at 3:49pm revealed the ceiling light fixture globe had several dead bugs.</p> <p>Observation of the wall in the hallway to the right of room #38 on 8/16/16 at 3:50pm revealed a live roach crawling on the wall.</p> | D 079 | | |
| | <p>Observation of the SCU dining room on 8/16/16 at 3:52pm revealed there were several dead bugs in all fluorescent ceiling light covers.</p> <p>Observation of the SCU enclosed outdoor patio area on 8/16/16 at 3:55pm revealed: -There were numerous cigarette butts on the ground at the entrance of the gazebo. -There were 10 wasp nests under the roof of the gazebo. -There were ants crawling on all chairs and benches under the gazebo.</p> <p>Observation of the gazebo to the right of the entrance of the facility on 8/16/16 at 4:00pm revealed: -There were 11 wasp nests with several flying wasps under the roof of the gazebo. -There were numerous ants crawling over the wooden benches under the gazebo roof line.</p> <p>Interview with Housekeeping Supervisor on 8/16/16 at 10:26am revealed: -The staff were instructed by the Administrator to</p> | | | |

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| D 079 | <p>Continued From page 22</p> <p>use water and vinegar to clean rooms identified with bed bugs.</p> <ul style="list-style-type: none"> -The vinegar-water solution was ineffective as he had to retreat the same rooms frequently. -Bed bugs had been seen in 3 rooms after having treated those rooms with vinegar-water solution. -The pest control service had sprayed several rooms in the facility on 8/11/16. -Residents in rooms identified as having bedbugs had their laundry cleaned separately. <p>Confidential interviews with 6 staff members revealed:</p> <ul style="list-style-type: none"> -The facility had hired a pest control service 5 years ago with industrial equipment to steam away the bed bugs but that pest control service had not returned since. -The pest control service technicians do not spray the entire facility each time they visit, only certain rooms considered "hot spots of activity." -The facility needed to be professionally cleaned and sprayed top to bottom for bugs. -The bedding in the entire facility needed to be replaced because the bed bugs hid everywhere. -The facility did not address wasps or ants. -Only the manager could call the pest control company if a resident complained. -The pest control company recommended that the entire facility be sprayed, not just one or two rooms. <p>Interview with Maintenance Supervisor on 8/16/16 at 10:42am revealed:</p> <ul style="list-style-type: none"> -He used the vacuum cleaner to vacuum bed bugs, wasps, ants, roaches "just to keep them in check." -The vacuum did not eradicate the bugs but was helpful. -He would vacuum resident beds and belongings if there was an identified bed bug problem. | D 079 | | |

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| D 079 | <p>Continued From page 23</p> <p>-He did not vacuum the floors, window sills or air-conditioners of the facility to clean up the dead bugs.</p> <p>Record reviews from the facility's pest control service records revealed:</p> <p>-On 2/8/16, room #4 and #6 were treated for bedbugs and household pests using steam and baseboard and spot treatment.</p> <p>-On 3/23/16, room #7, #12, and #30 were treated for bedbugs and household pests using steam and baseboard and spot treatment.</p> <p>-On 4/27/16, room #7, #12, and #30 were treated for bedbugs and household pests using steam and baseboard and spot treatment.</p> <p>-On 6/17/16, room #4, #37, and #41 were treated for bedbugs and household pests using steam and staff was told to put all clothes and linens in dryer for 45 minutes on high heat setting.</p> <p>-On 7/18/16, room #11 and #15 were treated for bedbugs and household pests using steam and crack and crevice which incorporated spraying the perimeter floor and window sills in each room.</p> <p>-On 8/11/16, room #9, #10, #15, #30 and #11 and #15 were treated for bedbugs and household pests using steam and crack and crevice.</p> <p>Telephone interview with the facility's pest control company's owner on 7/28/16 at 11:00am revealed:</p> <p>-The facility would not have issues with pests, especially bed bugs if they followed key recommendations which included notifying the pest control company immediately of any bedbug finding, treating the identified room, and keeping the affected resident in the same room as the bedbugs while vacuuming daily for 14 days after the initial treatment.</p> <p>-The pest control company treatments flushed out pests from the walls only, so if the facility failed to</p> | D 079 | | |

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NAME OF PROVIDER OR SUPPLIER
RIVERVIEW

STREET ADDRESS, CITY, STATE, ZIP CODE
**3407 OAK ROAD
NEW BERN, NC 28563**

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| D 079 | <p>Continued From page 24</p> <p>vacuum the pests, the same pests would return back into the walls.</p> <p>-Part of the facility's problem was that they were removing the bedbug-covered resident to a temporary room, thereby infesting another room, while they treated the resident's primary room.</p> <p>-The pest control company sprays all rooms monthly as contracted by the facility.</p> <p>-The pest control company technicians inspect all areas of the facility and treats all pest problems the same day.</p> <p>-The duration of a major bedbug or roach infestation was approximately 6 months to resolution.</p> <p>-The facility's bug problem should be under control within the next two months since they have been treating consistently for bedbugs for the last few months.</p> <p>-The pest control company can complete eradication of any bedbug or roach problem in 21 days if the facility was willing to pay for the extra expense for the 21-day intense treatment.</p> <p>A second telephone interview with the owner of the facility's pest control service on 8/17/16 at 12:10pm revealed:</p> <p>-The facility was instructed to vacuum all dead bugs for 14 days after treatment for all rooms to prevent a reoccurrence of an infestation.</p> <p>-If the facility did not vacuum or sweep away the dead roaches on the floor, any egg sacks on a dead roach would hatch repeating the same problem.</p> <p>-Part of the pest control technician's responsibility was to sweep and treat all eves and soffits outside the facility for spiders, wasps and bugs each month as part of the facility's contract.</p> <p>-He could not explain why the eves and soffits were not addressed by his company.</p> <p>-The facility was educated to use vinegar and</p> | D 079 | | |

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| D 079 | <p>Continued From page 25</p> <p>water solution as a barrier for the bedbugs from entering other parts of the facility and not as an insecticide.</p> <p>-The facility Administrator, Facility Manager and housekeeping staff had been educated by the pest control technician on the need for identification of residents causing the bedbug problems and not to simply move the same resident to another room where the new infestations had been arising according to their records.</p> <p>-They discussed with the facility the need for tracking problem residents who were bringing in bedbugs to protect the other residents' rights.</p> <p>Interview with Resident #3's Guardian on 8/16/16 at 9:55am revealed:</p> <p>-She was not aware that the facility had an issue with bedbugs or roaches until last month.</p> <p>-She had transported Resident #3 to one of his medical providers and upon return to the facility, she was told by a PCA (Personal Care Aide) and Medication Aide that she should clean her car due to the abundance of bedbugs and other pests.</p> <p>Interview with housekeeping staff on 7/26/16 at 11:00 am revealed:</p> <p>-There were still bedbugs in the facility.</p> <p>-There were bedbugs seen on 7/26/16 in room #15.</p> <p>-He took all of the resident's clothes except what the resident was wearing to laundry and had them dry the clothes on high heat for 1 hour.</p> <p>-He used vinegar to spray all the surfaces in the room and then wiped everything down.</p> <p>-The vinegar solution that he was told to use by the Facility Manager did not seem to be working.</p> <p>Review of the current Food Establishment</p> | D 079 | | |

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| D 079 | <p>Continued From page 26</p> <p>Inspection Report revealed:</p> <ul style="list-style-type: none"> -The report was dated 8/11/16. -There was an Observation and Corrective Action Report citing a large wasp nest by the kitchen door. -There was an Observation and Corrective Action Report citing numerous live and dead roaches seen throughout the kitchen and dry storage area. -There was an Observation and Corrective Action Report citing live roaches on and in boxes of sweet potatoes on the prep counter. -There was a recommendation that the Administrator "work with the pest control operator to eliminate pest and harborage areas throughout the facility." | D 079 | | |
| | <p>Interview with the Administrator on 8/11/16 at 12:30pm revealed:</p> <ul style="list-style-type: none"> -There had been a problem with bedbugs since January 2015. -He suspected the resident in room #11 is bringing them into the facility. -The resident was very confrontational when his room was cleaned or being treated for pests. <p>Interview with the Administrator on 8/16/16 at 12:00pm revealed:</p> <ul style="list-style-type: none"> -He had already addressed the bedbug issue and was working with the pest control company to eradicate the problem. -The pest control company had sprayed the entire facility on 8/11/16 and identified 5 rooms with bedbugs. -The staff know to regularly vacuum any rooms with bedbugs daily and to use the vinegar solution. -He was unaware of rooms that currently had dead bugs on the floors, window sills and on top of the air-conditioner units. | | | |

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| D 079 | <p>Continued From page 27</p> <ul style="list-style-type: none"> -He did not know why the staff had not vacuumed the dead bugs off the window sills, floors and air conditioner units yet. -He would ensure that the staff would immediately go room-to-room and identify all rooms with bugs to be vacuumed. <p>Interview with the Owner of the facility on 8/17/16 at 10:35am revealed:</p> <ul style="list-style-type: none"> -The facility had a contract with a licensed pest control company. -The Administrator has a bedbug checklist which was implemented today based on last week's pest control inspection. -Affected rooms with known bedbugs will be checked and documented daily. -The facility Administrator, Facility Manager and Owner were working together with the pest control company to eradicate the problem. -The Administrator was responsible for ensuring the staff follow the recommendations of the pest control company. -The Administrator was in regular contact with the pest control company if any pest issues arose. <hr/> <p>Review of the facility's Plan of Protection dated 8/17/16 revealed:</p> <ul style="list-style-type: none"> -A new housekeeping bedbug checklist will be created and implemented today. -Residents affected by bedbugs will be checked and documented daily. -All linens and clothing will be checked in this process and will follow our protocol for cleaning. -Rooms identified as having bedbugs will be inspected and vacuumed daily. -Monthly pest control treatments will be completed per contract but will be called if live bugs are detected. -Known bedbug-affected residents will have a set of clean clothes bagged and kept at the nurse's | D 079 | | |

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| D 079 | Continued From page 28 station upon returning to the facility. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2016. | D 079 | | |
| D 087 | <p>10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:</p> <p>(1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following:</p> <p>(A) at least one pillow with clean pillow case;</p> <p>(B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and</p> <p>(C) clean bedspread and other clean coverings as needed;</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations and interviews, the facility failed to provide or maintain at least one pillow with clean pillow case, a clean top and bottom sheet on the bed and a clean bedspread or other coverings as needed for 32 of 48 resident beds.</p> | D 087 | <p>The facility owner has purchased new mattresses, box springs, fitted sheets, pillow cases, flat sheets, wash cloths and towels.</p> <p>These items will be placed in every room identified during survey. The compliance officer will do weekly checks along with housekeeping to ensure that any item needing to be replaced can be done promptly. In addition, housekeeping has gone through and discarded all damaged linens, broken furniture. The PCA will also check beds daily and as needed on all shifts to ensure that all rooms have clean linen at all times.</p> | 10/31/16 |

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| D 087 | Continued From page 29 The findings are: Observations made on the Assisted Living Hall during the initial tour of the facility on 8/15/16 between 10:20am and 12:15pm revealed: -In Resident Room #1, the bedspreads on both beds had stains, were covered in dead gnats and had no pillow -In Resident Room #2, the bedspreads on both beds had stains and was covered in dead gnats. -In Resident Room #3, there were dead bugs on the bedspreads on both beds and the pillows and pillow cases were dirty. -In Resident Room #6, there were several dead gnats on the bedspreads on both beds and both pillow cases were dirty. -In Resident Room #7, there were several dead gnats on the bedspreads on both beds, and a roach on the bed by the window. -In Resident Rooms #8, #9, #10, and #11, the sheets were stained, pillow cases were dirty, the pillow was yellowed and there were several dead gnats on top of the bedspread. -In Resident Room #13, there were several gnats on the bedspread. -In Resident Room #16, the mattress was extremely moldy, there were stained sheets and bedspread and there were gnats on the bedspread. -In Resident Room #17, both bedspreads were heavily stained, the sheets and pillow cases were noticeably dirty and grey, and there were gnats on both beds. -In Resident Room #24, the bedspread was covered with grease stains and had a splattered dead roach on the fabric. -In Resident Room #25, the sheets were stained and dirty, the bedspread had multiple gnats and was stained, and there were gnats on the dirty pillow case. | D 087 | This will be reviewed daily by the facility manager and RCC to ensure that its being completed and that the furnishings and linens are available for residents. The facility compliance officer will also be completing a daily bed bug check in each room to ensure that there are no bed bugs. This check is documented and reviewed weekly and as needed by Facility Manager and Administrator. | 10/31/16 | |

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| D 087 | <p>Continued From page 30</p> <ul style="list-style-type: none"> -In Resident Room #29, the sheets were stained, and there were several gnats on top of the bedspread. -In Resident Room #30, there was a light green plastic covered pillow with no case which was heavily torn in multiple places which set on top of a stained bedspread. -In Resident Rooms #26, #27, #28, #32, #33, #34, #35, #36, #37, #38, #39, #40, and #41 had dead gnats on the bedspreads. -In Resident Room #42, #43, and #44, there were gnats on the stained bedspreads, the sheets were stained and pillow cases were dirty. <p>Confidential interview with 18 residents revealed:</p> <ul style="list-style-type: none"> -The bedding and sheets were supposed to be washed when we requested it. -The facility had someone for bugs on 7/10/2016 which is where all of the dead bugs came from. -The facility had not washed any of the linens since they sprayed for pest control. -The sheets are always stained because they are old. -The bedspreads had always been stained. -Housekeeping had not cleaned up the dead bugs off of the bedspreads. -Sometimes residents slept directly on the plastic mattress because the sheets were too dirty. -Sometimes residents did not have any sheets and only used a bedspread. -Residents were not allowed to use the laundry room. -Residents had to give their linens to the laundry room staff for laundering. -Roaches and bugs were part of daily life at the facility. -Several of the residents had stopped asking for clean linens because "it did not do any good." -None of the facility staff offered to clean their beds or linens. | D 087 | | |

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| D 087 | <p>Continued From page 31</p> <ul style="list-style-type: none"> -If they wanted their bedding cleaned, they would bring it to the laundry room area. -Housekeeping staff would occasionally mop the floors but do not vacuum bugs off of the beds. -The Maintenance Director did not vacuum up dead bugs. -They wanted the facility to "vacuum up" all of the dead bugs. -They wanted to facility to continuously spray for existing roaches and bedbugs. -The residents had complained to the manager several times each week regarding the need for better pest control with no results. -The pest control technician would spray only certain rooms, not all rooms when he visited the facility. -The facility has had a bug problem for years. <p>Confidential interviews with 3 staff revealed:</p> <ul style="list-style-type: none"> -All sheets, bedspreads and pillows in the residents rooms had stains. -The facility did not have new linens to replace stained linens. -They tried to clean the stains from the linens but because they were old, many of the stains were permanent. -There were insufficient staff to handle the laundry needs of the residents. -Residents would notify staff when they needed items laundered. -Residents were not allowed to launder their own linens. -There were always dead bugs on the bedspreads on a daily basis. -They were instructed to spray the baseboards of each room with vinegar and water "to control the bug population." -The staff were told to meet the resident's laundry needs but there weren't enough staff. -They used a vacuum that was approved by the | D 087 | | |

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| D 087 | <p>Continued From page 32</p> <p>Administrator to get rid of roaches, bedbugs and other bugs if a resident's bedding was infested.</p> <ul style="list-style-type: none"> -The vacuum did not eradicate the bugs but reduced the amount of bugs significantly. -The pest control service did not spray every room, only certain rooms which had complaints of bugs. -The pest control service was not effective. -Housekeeping staff worked until 3pm daily which was not enough time to address all the cleanliness issues of the facility including cleaning up dead bugs and laundering bedding. <p>Interview with Facility Manager on 8/16/16 at 3:00pm revealed:</p> <ul style="list-style-type: none"> -The residents notified housekeeping staff when they needed anything laundered. -The housekeeping staff checked each room daily for resident laundry needs. -The housekeeping staff was instructed to check each room for dirty linens, bedspread and pillow cases and wash them if needed. -There were no current complaints about the bedding cleanliness. -She did not check each room on a daily basis for cleanliness. <p>Interview with the Administrator on 8/16/16 at 3:30pm revealed:</p> <ul style="list-style-type: none"> -He was unaware any current laundering needs of the residents' bedspreads, sheets or pillow cases. -He would go through each room and inspect pillows and pillow cases to ensure they are clean and in good repair. <p>Interview with the Owner on 8/17/16 at 10:15am revealed:</p> <ul style="list-style-type: none"> -He was unaware of the cleanliness condition of the sheets, bedspread and pillow cases. -He would ensure they would be inspected and | D 087 | | |

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| D 087 | <p>Continued From page 33</p> <p>cleaned if necessary.</p> <p>-The facility had sprayed for bugs on August 11, 2016 so there were many dead bugs in the facility.</p> <p>-He was not aware there were dead bugs on most of the resident bedspreads in the facility.</p> <p>-He would inspect those rooms with bugs on the bedspreads and have them cleaned immediately.</p> <p>-He had not had instructed anyone to clean the dead bugs found in resident rooms since the last pest control service on August 11, 2016.</p> <hr/> <p>The Facility submitted a Plan of Protection dated 8/17/16 as follows:</p> <p>-The Administrator and Facility Manager will inspect all sheets, pillows, pillow cases to ensure they are in good repair.</p> <p>-Any bedding or pillows found in poor condition will be discarded and replaced.</p> <p>-Housekeeping will inspect all rooms and launder all bedding in need of cleaning.</p> <p>CORRECTION DATE FOR TYPE B VIOLATION NOT TO EXCEED OCTOBER 1, 2016.</p> | D 087 | | |
| D 091 | <p>10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:</p> <p>(5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising;</p> <p>(6) additional chairs available, as needed, for use by visitors;</p> <p>This Rule shall apply to new and existing</p> | D 091 | | |

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| D 091 | <p>Continued From page 34</p> <p>facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a chair for 45 of the 48 residents' rooms. The findings are:</p> <p>Observations of all resident rooms on 8/16/16 between 10:00am and 12:00pm revealed that 45 of 48 residents did not have personal chairs in their rooms.</p> <p>Confidential interviews with 10 residents revealed:</p> <ul style="list-style-type: none"> -There were no chairs provided in the rooms. -None of the residents had previously had a chair in their room. -The residents would like to have a chair by their beds. -Friends or family had to sit on a resident's bed when visiting. -They did not know they could have a chair in the room. -Two of the facility's resident rooms had one chair. <p>Interview with the Administrator on 8/16/16 at 2:00pm revealed:</p> <ul style="list-style-type: none"> -He was unaware of a rule requiring a personal chair for each resident. -He did not know how long each resident had been without a chair. -None of the residents had asked for a chair. <p>Interview with the Owner of the facility on 8/17/16 at 10:05am revealed:</p> <ul style="list-style-type: none"> -He was unaware of a rule requiring a personal chair for each resident. -He could not state how long each resident had been without a chair. | D 091 | <p>The facility owner has purchased new chairs for use in resident rooms. There will be 45 of 45 identified chairs during survey that will be replaced.</p> <p>The facility compliance officer and housekeeper will be doing daily and weekly checks to ensure that any identified furnishing can be replaced or repaired. This process will be monitored by the facility manager and overseen by the Administrator.</p> | 8/31/16 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025031 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 08/17/2016 |
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NAME OF PROVIDER OR SUPPLIER
RIVERVIEW

STREET ADDRESS, CITY, STATE, ZIP CODE
**3407 OAK ROAD
NEW BERN, NC 28563**

| (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 |
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| D 091 | Continued From page 35 -None of the residents had asked for a chair or he would have obtained them. -He would obtain chairs for each resident "if that is required." | D 091 | | |
| D 093 | <p>10A NCAC 13F .0306(b)(8) Housekeeping And Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping And Furnishings</p> <p>(b) Each bedroom shall have the following furnishings in good repair and clean for each resident:</p> <p>(8) a light overhead of bed with a switch within reach of person lying on bed; or a lamp. The light shall provide a minimum of 30 foot-candle power of illumination for reading.</p> <p>This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a personal lamp for 44 of the 48 residents. The findings are:</p> <p>Observations of all resident rooms on 8/16/16 between 10:00am and 12:00pm revealed that 44 of 48 residents did not have personal lamps in their rooms.</p> <p>Confidential interviews with 10 residents revealed:</p> <ul style="list-style-type: none"> -There were no lamps provided in the rooms. -None of the residents had previously had a lamp in their room. -The residents would like to have a lamp by their beds. -They could not read by the ceiling light because it was not bright enough. | D 093 | <p>The facility owner has purchased new personal lamps for the 44 identified missing lamps in resident rooms. There were also extra lamps purchased as replacements for damaged or missing lamps. The facility compliance officer will complete weekly checks to ensure that all residents have personal lamps in their rooms. This will also be checked monthly by the facility manager and priv by the Administrator.</p> | 10/31/16 |

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| D 093 | <p>Continued From page 36</p> <ul style="list-style-type: none"> -They did not know they could have a lamp in the room. -Some of the rooms had brass wall mount lamps that had no bulbs. -They were not offered a lamp since coming to the facility. -Residents had to get out of bed to turn on the light. <p>Interview with the Administrator on 8/16/16 at 2:00pm revealed:</p> <ul style="list-style-type: none"> -He was unaware of a rule requiring a bedside lamp for each resident. -He could not state how long each resident had been without a bedside lamp. -None of the residents had asked for a lamp. <p>Interview with the owner of the facility on 8/17/16 at 10:05am revealed:</p> <ul style="list-style-type: none"> -He was unaware of a rule requiring a bedside lamp for each resident. -He could not state how long each resident had been without a lamp. -None of the residents had asked for a lamp or he would have obtained them. -He would obtain lamps for each resident. | D 093 | | |
| D 105 | <p>10A NCAC 13F .0311(a) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the electric baseboard heaters,</p> | D 105 | <p>The facility has hired a construction company who will be coming in to remove all of the baseboard heaters that are not operational and cannot be fixed. They will be repairing those that are able to be repaired. The construction company will</p> | |

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| D 105 | <p>Continued From page 37</p> <p>air conditioners and ceiling lights throughout the facility were maintained in a safe operating condition.</p> <p>The findings are:</p> <p>Observations made on the Assisted Living Hall during the initial tour of the facility on 8/15/16 between 10:20am and 12:15pm revealed the following:</p> <ul style="list-style-type: none"> -The lobby men's bathroom had one of two blown light bulbs in the fixture. -The lobby women's bathroom had one of two blown light bulbs in the fixture. -Resident room #3 had 2 missing bulbs from the 2-socket ceiling light fixture. -Resident room #3's air conditioner intake vent was heavily clogged with dust. -Resident rooms #4, #6, #7, #8, #9, #12, #13, #14, and #15 had 1 bulb missing from the 2-socket ceiling light fixture. -Resident room #16 had a non-working ceiling light. -Resident room #18's air conditioner was missing the cover grate. -Resident room #18 had 1 bulb missing and a missing ceiling lamp shade had 1 bulb missing from the 2-socket ceiling light fixture. -Resident room #19 had 1 bulb missing from the 2-socket ceiling light fixture and an air conditioner vent covered in dust. -Resident room #20 had a non-working window air-conditioner, a piece of cardboard adjacent to the air-conditioner to block the outside air, and a non-working light fixture. -Resident room #21 had a missing grate cover on the air-conditioner unit and a single lamp with no shade or bulb. -Resident room #22 had 1 bulb missing from the 2-socket ceiling light fixture, a broken baseboard | D 105 | <p>also be repairing and replacing all air conditioners and ceiling lights that were identified as needing to be replaced or repaired during the survey.</p> <p>The facility compliance officer will be completing daily walkthroughs to check and make everything is maintained in a safe operating condition. The facility Manager will be conducting weekly checks and the Administrator as needed.</p> | 10/31/16 |

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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW | STREET ADDRESS, CITY, STATE, ZIP CODE 3407 OAK ROAD NEW BERN, NC 28563 |
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| D 105 | <p>Continued From page 38</p> <p>radiator panel and missing knobs on the air-conditioner unit.</p> <p>-Resident room #23 had 1 bulb missing from the 2-socket ceiling light fixture.</p> <p>-Resident room #24 had 1 bulb missing from the 2-socket ceiling light fixture.</p> <p>-Resident room #25 had 1 bulb missing from the 2-socket ceiling light fixture and a detached metal baseboard heater cover plate.</p> <p>-Resident room #26 had a baseboard heater with a partially detached 8-foot sharp-edged cover plate and the air conditioner was sitting on the floor.</p> <p>-Resident room #27 had 1 bulb missing from the 2-socket ceiling light fixture and no air conditioner unit.</p> <p>-Resident room #28 had 1 bulb missing from the 2-socket ceiling light fixture and a detached baseboard heater cover plate.</p> <p>-Resident room #30 had 1 bulb missing from the 2-socket ceiling light fixture and an unplugged two-lamp brass colored wall sconce with no bulbs and dusty shades.</p> <p>-Resident room #31 had 2 of 2 blown bulbs from the 2-socket ceiling light fixture and an active water leak by the light fixture.</p> <p>-There was a hallway ceiling fan in the assisted living hallway to the left of the lobby with no working light and 1 of 5 fan panels missing.</p> <p>-There was a hallway ceiling fan in the special care unit hallway to the right of the lobby with no working light and 1 of 5 fan panels missing.</p> <p>-Resident room #34 had 1 bulb missing from the 2-socket ceiling light fixture.</p> <p>-Resident room #35 had a baseboard heater with no knob and 1 bulb missing from the 2-socket ceiling light fixture.</p> <p>-Resident room #38 had 1 bulb missing from the 2-socket ceiling light fixture.</p> <p>-Resident room #39 had an air-conditioner set on</p> | D 105 | | |

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| D 105 | <p>Continued From page 39</p> <p>65-degrees blowing out 87-degree air.</p> <ul style="list-style-type: none"> -There were 3 air-conditioner power cords (rooms #39, #41 and #44) that ran through the middle of the plastic window blind slats to connect to the ceiling outlet. -The baseboard heaters were on both the men's and women's common-use bathrooms on the assisted living hallway where the temperature in each bathroom was 98-degrees. <p>Confidential interviews with 15 residents revealed:</p> <ul style="list-style-type: none"> -The facility staff installed only one bulb in each 2-socket ceiling fixture per instructions of the Facility Manager. -It was hard to read or see inside the rooms by the low wattage bulb in the ceiling fixture in the late evening. -Some of the air-conditioner units were replaced because they were failing. -The baseboard covers were a hazard because residents could easily hit their foot on them if their bed was by the window. -Residents would sometime hit the edge of their bed when they shut the ceiling light off at night when walking to their beds in the dark. -The rooms needed more lighting. -Some of the baseboard heaters were on constantly, even in 100-degree temperatures. -Residents did not use the toilet by the baseboard heater in the bathrooms because it was too hot. -Most of the resident rooms had blown ceiling lights. -Several of the air-conditioner units did not have any knobs so residents have to call maintenance to get a pair of pliers to change the temperature in their rooms. <p>Confidential interviews with 3 staff members revealed:</p> | D 105 | | |

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| D 105 | <p>Continued From page 40</p> <ul style="list-style-type: none"> -Light bulb replacement requests were considered unimportant if residents already had one bulb. -The Maintenance Director did not place much importance on general building maintenance unless told specifically by the Administrator. -Most everything in the facility needed to be fixed and it was too much for just the one maintenance person. -Staff "made due" with what they had to work with when it came to repairs and replacements. -The baseboard heaters were so old and hazardous to anyone as they hit the edge of a detached cover plate with their foot when walking by the heater. -There is no schedule for cleaning air-conditioner vents, checking bulbs or identifying hazards. <p>Interview with the Maintenance Director on 8/16/16 at 2:42pm revealed:</p> <ul style="list-style-type: none"> -He does have an inspection schedule or does a facility walk-thru to identify items in need of repair. -He only fixes things if the aides tell him that something is broken. -He did not vacuum the dusty air-conditioner vents. -He was unaware that any bulbs needed replacement. -He was unaware that any baseboard heaters needed to be fixed or were without knobs. -He was unaware that some of the baseboard heaters were currently on in the bathrooms. -He was unaware of two resident air-conditioner units that were blowing heat and not functioning properly. -He shrugged and gave no answer when asked if he did a walk through the facility on a regular basis to identify things that needed to be fixed or replaced. -Loose baseboard heater covers, missing | D 105 | | |

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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW | STREET ADDRESS, CITY, STATE, ZIP CODE 3407 OAK ROAD NEW BERN, NC 28583 |
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| D 105 | <p>Continued From page 41</p> <p>air-conditioner vents and missing bulbs "were not that big of a deal." -He had not identified anything worthwhile recently to mention to the Facility Manager.</p> <p>Interview with the Administrator on 8/16/16 at 2:45pm revealed: -The building was having new air-conditioner units installed presently. -He was unaware that some of the baseboard heaters were currently on. -He was unaware that the detached baseboard heaters covers posed a laceration hazard. -He was unaware that the ceiling fixtures in any of the rooms were in needs of bulbs. -He was unaware that the air-conditioner power cords were considered an electrical hazard when ran through the window blinds. -He was unaware that two of the ceiling fans in the main hallway each had a missing paddle. -The facility did not have a to-do list for items needing repair.</p> <p>Interview with the Owner on 8/17/16 at 10:15am revealed: -He was unaware that the majority of rooms at the facility had missing or blown light bulbs. -He walked through the facility on a regular basis and had not noticed any problems with ceiling fans, ceiling lights, baseboard heaters or air-conditioners. -The facility had new air-conditioner units which replaced non-functioning units as needed. -He was unaware that the 8-foot long cover plates on the baseboard heaters were detached or missing in several of the resident rooms. -He was unaware that the baseboard heaters were running in the men's and women's common use bathrooms creating 98-degree or higher environment.</p> | D 105 | | |

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| D 105 | Continued From page 42 -He would immediately inspect all rooms and hallways for any ceiling fans, ceiling lights, baseboard heaters and air conditioner that required repair or replacement. -His expectation was that the staff identify and fix or repair any items needing attention. -No residents or staff had informed him of anything currently needing repairs. | D 105 | | |
| D 164 | 10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. | D 164 | The facility pharmacy nurse has provided Training on Care of Diabetic Residents to all medication staff. The facility nurse will be completely monthly Training on Care of diabetics residents to ensure that all medication aides are trained prior to providing this care. The business officer manager will oversee this process and the Facility Manager will do weekly checks to ensure that this process is followed and the training is completed. | 10/21/16 |

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| D 164 | <p>Continued From page 43</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews, and interviews the facility failed to assure that all Medication Aides had received diabetes training prior to passing medications to residents that have a diagnoses of diabetes for 2 of 4 sampled Medication Aides (Staff B and Staff C).</p> <p>The findings are:</p> <p>1. Review of Staff B's personnel file revealed: -She as hired at the facility on 12/23/14 as a Medication Aide. -There were no record of Staff B completing diabetes training.</p> <p>Refer to Interview with Facility Manager on 08/17/16 at 10:50 AM.</p> <p>Refer to Interview with the Administrator on 08/17/16 at 11:30 AM.</p> <p>2. Review of Staff C's personnel file revealed: -She was hired at the facility on 06/30/16 as a Medication Aide. -There was no record of Staff C completing diabetes training.</p> <p>Refer to Interview with Facility Manager on 08/17/16 at 10:50 AM.</p> <p>Refer to Interview with the Administrator on 08/17/16 at 11:30 AM.</p> <p>Interview with the Facility Manager on 08/17/16 at 10:50 AM revealed: -All Medication Aides are required to have diabetes training. -She was aware that diabetes training was</p> | D 164 | | |

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| D 164 | Continued From page 44 required for all Medication Aides before they can administer insulin to residents who requires insulin. -The Medication Aides can receive training either on the internet through the pharmacy website or with the in-services training that is done by a contracted company. -The office manager is responsible for making sure all training has been done. -She was not aware that there were staff members that had not received their diabetes training. Interview with the Administrator on 08/17/16 at 11:30 AM revealed: -All Medication Aides should receive their diabetic training as part of the initial training process. -It was his job to make sure that all training is done by staff. | D 164 | | |
| D 238 | 10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. | D 238 | | |

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| D 238 | <p>Continued From page 45</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure that the information provided on the current FL2's including the residents diet order had been clarified by a prescribing practitioner for 3 of 5 sampled (Resident #1, Resident #2, and Resident #4).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated for 04/16/16 revealed: -Diagnoses included falls, Type 2 Diabetes, Vascular Dementia, and Major Depression. -There was no a diet order on the current FL2.</p> <p>Review of a physician's diet order for Resident #1 dated for 03/11/16 revealed and order for a no concentrated sweets and mechanical soft diet.</p> <p>Observation of breakfast served to Resident #1 on 08/17/16 at 8:10 AM revealed -The Resident being served French toast sticks and syrup and was not sugar free. -The resident added the syrup to his French toast and ate 100%.</p> <p>Review of the facility's approved therapeutic diet menu on 08/17/16 revealed residents receiving a no concentrated sweets diet should be served sugar free beverages, gelatins, syrups, jelly, and sweeteners except when being served milk.</p> <p>Refer to interview with Dietary Manager on 08/17/16 at 8:52 AM.</p> <p>Refer to interview with the Facility Manager on 08/17/16 at 10:50 AM.</p> | D 238 | <p>The facility RCC will complete a thorough check of all current residents FI-2's and orders to ensure all orders have been properly clarified as ordered.</p> <p>The facility RCC and Facility manager will be responsible for reviewing all new orders to ensure that the FI-2 has been completely and accurately completed and all orders are clarified as needed. This process will be reviewed weekly and PRN by the Administrator</p> <p>The RCC will also be monitoring to ensure that all residents diets are given to the Dietary Manager to ensure that the correct diets are posted and served. The Dietary Manager will ensure that all dietary staff have been properly trained on the therapeutic diets to ensure that they are served the proper way.</p> | <p>10/31/16</p> <p>10/31/16</p> |

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| D 238 | <p>Continued From page 46</p> <p>Refer to interview with the Administrator on 08/17/16 at 11:30 AM.</p> <p>2. Review of Resident #2's current FL2 dated for 06/24/16 revealed: -Diagnoses included hypertension, chronic alcoholism, and homelessness. -There was not a diet order on the current FL2.</p> <p>Review of a physician's diet order for Resident #2 dated for 12/10/15 revealed an order for a regular no added salts diet which includes no salt at the table.</p> <p>Observation of the dining room tables in the dining room on 08/16/16 at 7:55 AM revealed that 9 out of 9 tables had salt on the tables for residents to use.</p> <p>Observation of breakfast served to Resident #2 on 08/17/16 at 8:20 AM revealed there was a bottle of salt on the table and Resident #2 took the top off of the bottle and was pouring salt all over his food and then ate his plate of food.</p> <p>Review of the facility's approved therapeutic diet menu on 08/17/16 revealed residents receiving a no added salt diet should not be served no more than 3-4 grams of salt per meal.</p> <p>Refer to interview with dietary manager on 08/17/16 at 8:52 AM.</p> <p>Refer to interview with the Facility Manager on 08/17/16 at 10:50 AM.</p> <p>Refer to interview with the Administrator on 08/17/16 at 11:30 AM.</p> <p>3. Review of Resident #4's current FL2 dated for</p> | D 238 | <p><i>This process will be managed daily by the Dietary Manager, the Facility daily and weekly. The Administrator will monitor this process as needed.</i></p> | 10/31/16 |

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| D 238 | <p>Continued From page 47</p> <p>06/17/16 revealed: -Diagnoses included Diabetes Mellitus, Respiratory Failure, Acute Renal Failure, Chronic Obstructive Pulmonary Disease, Lithium Toxicity, Morbid Obesity, hypertension, and Dehydration. -There was not a diet order on the current FL2.</p> <p>Review of a Physician's diet order for Resident #4 dated for 12/18/15 revealed: -An order for a regular no added salts diet which includes no salt at the table. -An order for a no concentrated sweets diet.</p> <p>Observation of breakfast served to Resident #4 on 08/17/16 at 8:10 AM revealed: -The Resident being served French toast sticks and syrup and was not sugar free. -The resident added the syrup to his French toast and ate 100%. -There was a box that contained salt on the table and Resident #2 was putting salt all over his food and then ate his plate of food. -There were no staff observing resident while he was putting salt on his food.</p> <p>Review of the facility's approved therapeutic diet menu revealed: -Residents receiving a no concentrated sweets diet should be served sugar free beverages, gelatins, syrups, jelly, and sweeteners except when being served milk. -Residents receiving a no added salt diet should not be served no more than 3-4 grams of salt per meal.</p> <p>Refer to interview with Dietary Manager on 08/17/16 at 8:52 AM.</p> <p>Refer to interview with the Facility Manager on 08/17/16 at 10:50 AM.</p> | D 238 | | |

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| D 238 | <p>Continued From page 48</p> <p>Refer to interview with the Administrator on 08/17/16 at 11:30 AM.</p> <p>Interview with the Dietary Manager on 08/17/16 at 8:52 AM revealed:</p> <ul style="list-style-type: none"> -He started as the dietary manager on 08/15/16. -He did have some credentials for working in a kitchen but had never worked with serving therapeutic diets. -He had not received any formal training on serving therapeutic diets. -He was aware that some residents were to receive special diets, but was not sure how to serve these diets. -He thought that no concentrated sweets meant he was not allowed to use extra sugar or heavy syrups. -He thought no added salts diets meant they could not add salt to the food when they were preparing food. <p>Interview with the Facility Manager on 08/17/16 at 10:50 AM revealed:</p> <ul style="list-style-type: none"> -The dietary manager started working at the facility one week ago. -He had not received any formal training but has gotten some training on working in the kitchen. -He was trained on basics such as pureed foods and chopped foods but has not been trained thoroughly on the specific diets. <p>Interview with the Administrator on 08/17/16 at 11:30 AM revealed:</p> <ul style="list-style-type: none"> -The Dietary Manager did not start working at the facility until 08/15/16. -He had not had any formal training on serving therapeutic diets. -He had training on the different diets but has not been trained in serving the diets. | D 238 | | |

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| D 238 | Continued From page 49 -He was planning on doing training this week with the Dietary Manager but the state surveyors showed up for the annual inspection. | D 238 | | |
| D 273 | <p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE B Violation</p> <p>Based on observation, interview, and record review the facility failed to notify the prescribing practitioner about behavior issues including yelling, swinging at staff and residents, and spitting on staff and residents for 1 of 5 sampled residents (Resident #5).</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated for 06/08/16 revealed diagnosis of Organic Brain Syndrome 2% Trauma, Seizure Disorder, Hypothyroidism, Non Verbal, history of leukocytosis, history of hip fracture, Para paresis, and intermittent agitation.</p> <p>Observation of Resident #5 on 08/16/16 at 8:15 AM revealed: -Resident #5 was in the hallway hollering out at the personal care aide that was with him. -Resident #5 was spitting and swinging his arms at the personal care aide, and then attempted to spit on surveyor.</p> | D 273 | <p>It is the policy and procedure of the facility that the facility shall assure referral and follow-up to meet routine and acute health care needs of all residents.</p> <p>The facility will always respond to any and all behavior issues that arise with residents by notifying the residents physician, mental health provider, responsible party, local law enforcement (as needed) and the local department of social services via an incident report.</p> <p>The RCC and Facility manager will be responsible for ensuring that the proper persons have been notified and responsible to ensure that the orders</p> | |

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| D 273 | Continued From page 50 -The personal care aide then walked away and left Resident #5 unattended. -Resident #5 then attempted to pull a linen cart over on top of himself and one of the surveyors intervened and grabbed the linen cart. Interview with a Personal Care Aide on 08/16/16 at 8:18 AM revealed: -Resident #5 had behavior issues like this every day. -She told surveyor that she was going to get the Medication Aide and then left Resident #5 (Resident #5 was still spitting at surveyor and swinging his arms) with the surveyor to go get the Medication Aide. -When she returned she said the Medication Aide is busy giving medications right now and she was going to just take him to his room. -When Resident #5 started spitting and swinging at the Personal Care Aide again she said that she just can't handle him right now and walked away and left Resident #5 alone. Observation of Resident #5 on 08/16/16 at 8:25 AM revealed: -Resident # 5 continued to spit at different residents as they walked down the hallway. -Resident #5 also continued to holler and was now biting himself on the arm and fingers as well as smacking himself in the face. -Resident #5 was swinging his arms around at several different people as they walked by including surveyors, staff, and other residents. -He did not make contact and actually hit anyone, however he did spit on 2 different resident while they were walking through the hallway. Observation of another Personal Care Aide (PCA) with Resident #5 on 08/16/16 at 8:30 AM revealed: | D 273 | or necessary follow through have been completed. <i>see addendum</i> The Administrator will monitor this process weekly to ensure proper referral and follow follow-up to meet the acute and routine needs of residents healthcare needs. All residents with any mental Health diagnosis as primary diagnosis will be referred and followed by a mental Health provider. This process will be completed by the RCC and Facility manager and monitored weekly by the Administrator. The facility will further complete a training with all staff on dealing with residents with difficult behavior and will offer that training monthly thereafter for new employees. <i>10/2/16</i> <i>10/2/16</i> <i>10/3/16</i> | |

Addendum: Type B violation exceeds maximum correction date. Spoke with Administrator on 10/6/16. Actual correction date is: 10/1/16.

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| D 273 | <p>Continued From page 51</p> <ul style="list-style-type: none"> -A different PCA came down the hallway where Resident #5 was at in his wheel chair. -She would not get close to him but she did attempt to talk with Resident #5 and he just continued to holler and spit at her. -The PCA then asked another resident who was walking down the hallways to go on the other side of Resident #5 to get her a cart out of the corner. -The resident walked toward Resident #5 and as he got closer Resident #5 started spitting and swinging at him. -The other resident then started spitting back at Resident #5 and they were both spitting back and forth at each other. -Resident #5 then started hocking up snot and spit on the other Resident five times while he walked around him to go and get the cart for the PCA. -Resident #5 continue to spit and swing but did not make any more contact with spit or his hands to the other resident. <p>Observation of the Medication Aide on 08/16/16 at 8:36 AM revealed:</p> <ul style="list-style-type: none"> -The Medication Aide tried to calm Resident #5 down by talking to him. -Resident #5 appeared to be calming down once she started talking with him and then she started pushing him down towards his room. <p>Interview with a Personal Care Aide (PCA) on 08/16/16 at 9:15 AM revealed:</p> <ul style="list-style-type: none"> -She worked at the facility 3-5 days per week and felt that at least 3-4 days per week Resident #5 was having behavior issues just like the one he had earlier this morning. -She had seen Resident #5 spit, holler, bite himself, and attempted to spit and swing at other residents and staff members when he has these episodes. | D 273 | | |

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| D 273 | <p>Continued From page 52</p> <ul style="list-style-type: none"> -She attempted to calm him down but if she couldn't then she would go and get the Medication Aide. -She tried not to leave Resident #5 alone but she walked away this morning to get the Medication Aide because the surveyors were with Resident #5. -The Medication Aide told her when she went to get her the first time that she was doing blood sugars so that other residents could eat breakfast and she would be out later to check on Resident #5. -She had notified the Facility Manager at least once or twice about Resident #5's behaviors but did not say when she had notified the Facility Manager. -She said the facility manager told her that she would handle the situation. -Resident # 5 had been having these behavior issues ever since he was admitted to the facility. -She felt she had some training done related to dealing with combative residents since they were getting so many in-services done. -She got some training when she was first hired at the facility and they were getting in-services done once a month. <p>Interview with a second Personal Care Aide (PCA) on 08/16/16 at 10:00 AM revealed:</p> <ul style="list-style-type: none"> -She worked at the facility 4 days per week and Resident #5 would present with behavior issues just like the ones he had earlier today 3-4 days per week. -Resident #5 would attempt to hit, punch, kick, bite, and spit at residents and staff. -Resident #5 had another episode with his behavior about 20 minutes ago when the staff were attempting to put him in his bed. -She felt that Resident #5 had these behavior issues several times per day. | D 273 | | |

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| D 273 | <p>Continued From page 53</p> <ul style="list-style-type: none"> -She had not received any formal training in dealing with residents with behavior issues since she had been working here. -The only training she received was she shadowed another PCA for a few days to learn basic PCA stuff. -When Resident #5 has behavior issues she would just walk away from him and keep her distance until he decides to calm down. -Sometimes she would go and get the Medication Aide to come and assist with Resident #5. -She has never reported any issues with Resident #5 to the Facility Manager or the Resident Care Coordinator. <p>Review of Resident #5's record revealed:</p> <ul style="list-style-type: none"> -There was a Physician's order dated 12/23/15 to move Resident #5 to a Skilled Nursing Facility for placement. -There was not any communication or order from the primary Physician that Resident #5 was not to be placed in a Skilled Nursing Facility. <p>Interview with the Resident Care Coordinator (RCC) on 08/16/16 at 10:15 AM revealed:</p> <ul style="list-style-type: none"> -She had only been working about 1-2 weeks at the facility. -She did receive a class on behaviors with residents when she first started. -The Medication Aides were to handle any issues with resident behaviors. -The Medication Aides would diffuse the situation with any residents having behavior issues. -The Medication Aides should call the Facility Manager or the Administrator if they are unable to diffuse the situation. -She was unaware of Resident #5 ever having any behavior issues other than he hollered out on occasion. -She had never seen him bite himself or swing | D 273 | | |

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| D 273 | <p>Continued From page 54</p> <p>and spit at any residents or staff members.</p> <p>Attempted telephone interview with a third Personal Care Aide (PCA) on 08/16/16 at 11:52 AM revealed the PCA was unavailable for interview.</p> <p>Attempted telephone interview with a fourth Personal Care Aide (PCA) on 08/16/16 at 11:55 AM revealed the PCA was unavailable for interview.</p> <p>Telephone interview with a fifth Personal Care Aide (PCA) on 08/16/16 revealed: -He had been working here for almost 6 years and worked second shift 3-11 PM. -He had seen Resident #5 have behavior issues such as biting himself, spitting and hitting at other residents and staff members. -He would try to calm the resident down and take him outside to help diffuse the situation. -He would report issues to his supervisor which would be the Medication Aide on duty at that time. -He believed that he received some training at the facility about 7 months ago in working with residents with behavior issues.</p> <p>Telephone Interview with a sixth Personal Care Aide (PCA) on 08/16/16 at 2:10 PM revealed: -She worked at the facility on third shift. -She has seen Resident #5 hitting and spitting at other residents and staff members. -These behaviors happened on a daily basis. -She was instructed by the Medication Aide that when Resident #5 was having behavior issues to walk away and leave him alone until he calms down. -She reports any behavior issues to the Medication Aide on duty. -She has never seen the Medication Aides do</p> | D 273 | | |

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| D 273 | <p>Continued From page 55</p> <p>anything except leave the Resident alone until he calms down.</p> <p>-She has been working at the facility for 6 months and has not had any formal training on caring for residents with behavior issues.</p> <p>Attempted telephone interview with a Medication Aide on 08/16/16 at 12:05 PM revealed the Medication Aide was unavailable for interview.</p> <p>Attempted telephone interview with a second Medication Aide on 08/16/16 at 12:08 PM revealed the Medication Aide was unavailable for interview.</p> <p>Interview with a third Medication Aide on 08/17/16 at 8:25 AM revealed:</p> <p>-He has seen Resident #5 have behavior issues and episodes frequently.</p> <p>-Resident #5 would get upset and spit and staff and residents, bite and hit himself, and will swing and try to hit other residents and staff members.</p> <p>-He had told the Personal Care Aides to walk away and leave Resident #5 alone when he had behavior issues until he calmed down.</p> <p>Telephone interview with Resident #5's Primary Care Practitioner on 08/16/16 at 3:37 PM revealed:</p> <p>-She was not aware of Resident #5 having a lot of behavior issues.</p> <p>-She did remember Resident #5 having these issues and behaviors when he was first admitted to the facility.</p> <p>-She had planned on moving him to a higher level of care around the time he was admitted, but the Administrator told her that his behavior issues had gotten better.</p> <p>-She usually talked with the Resident Care Coordinator and the Administrator when she</p> | D 273 | | |

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| D 273 | <p>Continued From page 56</p> <p>came to see Resident #5 and they say he has not been having any problems.</p> <p>-She last saw Resident #5 on 07/29/16 and he did not have any behavior issues going on at that time and she was told by the facility that he had been doing fine.</p> <p>-She had not been made aware of any behavior issues that Resident #5 has been having.</p> <p>-She did expect the facility to notify her when Resident #5 is having these behavior issues.</p> <p>-She did feel that Resident #5 is a threat to himself and others when he is having an episode of his behavior issues and should never be left alone.</p> <p>Interview with the Facility Manager on 08/17/16 at 10:50 AM revealed:</p> <p>-She was not aware of Resident #5 having several behavior issues throughout the day.</p> <p>-She had never seen Resident #5 try to hit another resident or staff members.</p> <p>-She had seen him spit at staff and other resident but she does not feel that it has happened that often.</p> <p>-She was not aware of any staff members coming to her and reporting Resident #5's behavior issues.</p> <p>-Since Resident #5 was admitted in December of 2015 she can only remember about 5 times that he had episodes of behavior issues.</p> <p>-She has had a few resident 's come to her and complain about his hollering out but never about hitting or spitting on them.</p> <p>-The staff are required to provide care to Resident #5 when he is having behavior issues and not leave him alone.</p> <p>-All staff members have had formal training on how to handle residents with behavior issues.</p> <p>-The staff should try to talk with Resident #5 and try and calm him down and then try and move</p> | D 273 | | |

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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW | STREET ADDRESS, CITY, STATE, ZIP CODE 3407 OAK ROAD NEW BERN, NC 28563 |
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| D 273 | <p>Continued From page 57</p> <p>him to an area where other residents are not located.</p> <p>-She had never told any of the staff that they could leave him alone during his behavior episodes until he calms down.</p> <p>-She expected the staff to report any of Resident #5's behavior issues to her as well as the primary doctor as soon as they have happened.</p> <p>Interview with the Administrator on 08/17/16 at 11:30 AM revealed:</p> <p>-He did not feel that Resident #5 has had frequent behavior issues.</p> <p>-Resident #5 had issues with communication and would get upset because he can't respond.</p> <p>-The staff should be backing up away from Resident #5 during his behavior episodes but only to give him space.</p> <p>-The staff should never leave him alone.</p> <p>-Resident #5 has had several behavior issues in the past when he was first admitted in December of 2015.</p> <p>-He had gotten reports about Resident #5 hollering and spitting at staff but none about him hitting.</p> <p>-No reports were given to him in regards to Resident #5 spitting or hitting another resident at the facility.</p> <p>-When Resident #5 first arrived the primary practitioner did write an order for Resident #5 to be placed in a higher level of care, but he talked with the doctor because he felt the facility could provide care for Resident #5 and the order was retracted.</p> <p>_____</p> <p>Review of facility's plan of protection dated for 08/17/16 revealed:</p> <p>-Facility will provide hourly checks of Resident #5</p> | D 273 | | |

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| D 273 | <p>Continued From page 58</p> <p>sited in this rule to check and document overall well being of this resident beginning today.</p> <ul style="list-style-type: none"> -Provider will be contacted for changes in Resident #5's care plan. -Also to ensure that staff respond to any issues with Resident #5 that is reported by other staff or residents, and report these issues to the Resident Care Coordinator. -Staff will be offered additional training in caring for residents with agitation and on person centered care. -This training will be documented and filed in all staff charts. -Educate all staff to notify management with Resident #5's agitations and frustrations. <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2016.</p> | D 273 | | |
| D 282 | <p>10A NCAC 13F .0904(a)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview, and record review the facility failed to keep food safe and protected from contamination. Including the kitchen and dining room having one or more roaches on the floors and walls, having cleaning chemicals stored with food, and not cleaning the</p> | D 282 | <p>The facility has trained all new and existing dietary staff on the proper procedures for cleaning the kitchen, dining and food storage areas. The dietary staff will be cleaning and mopping the kitchen area and both dining rooms after each meal. The facility has also contracted with a pest control operator</p> <p><i>see addendum 10/31/16</i></p> | |

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| D 282 | <p>Continued From page 59</p> <p>floors and tables of the kitchen.</p> <p>The findings are:</p> <p>Observation of the Assisted Living Dining Room on 08/15/16 at 9:31 AM revealed:</p> <ul style="list-style-type: none"> -There was a brown sticky liquid on the dining room floor around the drink machine. -There was a dead roach in the corner of the entrance way of the dining room. -There was a roach crawling around on the light socket near the entrance of the kitchen from the dining room. -There was a second roach crawling on the serving table that was located in the dining room. -There were three chunks of watermelon on the floor near the sink of the dining room. -There was a third roach crawling around the side of the sink in the dining room. -Multiple black dirt particles all over the dining room floor. -There were multiple dead bugs and dried up black dust on 4 out of 4 window seals in the dining room. <p>Observation of the kitchen area on 08/15/16 at 9:43 AM revealed there were several live and dead roaches all over the walls and floors of the kitchen area.</p> <p>Observation of the reach in cooler on 08/15/16 at 9:45 AM revealed there was an opened package of sausage in the cooler that was not labeled and not placed into a sealed container.</p> <p>Observation of the reach in freezer on 08/15/16 at 9:48 AM revealed there was an opened package of meatballs that was not labeled and not placed into a sealed container.</p> | D 282 | <p>That comes to the facility monthly for service. The facility has the pest control operator is now coming weekly to ensure any type of pest issues are addressed promptly.</p> <p>The dietary manager will complete daily checks to ensure that all areas of dining room are kept clean. The facility Manager will complete weekly and pm checks for cleanliness and pest activity and report to the Administrator as needed.</p> <p>Addendum: Type B violation exceeds maximum correction date. Spoke with Administrator on 10/6/16. Actual correction date is: 10/1/16</p> <p><i>[Signature]</i></p> | <p>10/31/16 See Addendum</p> |

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| D 282 | <p>Continued From page 60</p> <p>Observation of the dry food storage area on 08/15/16 at 9:50 AM revealed:</p> <ul style="list-style-type: none"> -There were multiple bottles of bleach and dish washing cleaners that were stored on the same shelf as dry food products. -There were also multiple dead roaches on the floors and several live roaches crawling on the floors, walls, and on boxes of food stored in the dry food storage area. <p>-Observation of the dining room in the special care unit on 08/15/16 at 10:20 AM revealed:</p> <ul style="list-style-type: none"> -There were multiple dead bugs and roaches around the baseboards and corners of the dining room floor. -Several dried up orange stains around the tables and center of the dining room floor. -The border on the bottom of the walls of the dining room had yellow and black stains that covered the borders. -There were dried up black and brown stains on multiple places of the dining room floors. <p>Interview with a Housekeeper on 08/17/16 at 10:20 AM revealed:</p> <ul style="list-style-type: none"> -The housekeeping staff were responsible for cleaning the floors and window seals of the dining room after each meal. -The Personal Care Aides were responsible for cleaning the table and chairs after each meal. -He had never seen the Aides doing the cleaning that they were required to do. -He would also clean up any spills or stains on the wall if they needed to be done but there was no set schedule. -There were always 2 housekeepers from 7 AM to 3PM one in the assisted living and one in the special care unit. -He had been seeing bugs in the kitchen and dining room for the last few weeks. | D 282 | | |

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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW | | STREET ADDRESS, CITY, STATE, ZIP CODE 3407 OAK ROAD NEW BERN, NC 28563 | | |
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| D 282 | <p>Continued From page 61</p> <ul style="list-style-type: none"> -The contracted exterminator was there last week and sprayed for the bugs. -He felt the bugs keep coming back because no one was doing any cleaning at night time after the housekeeping left. -The Personal Care Aides were responsible for cleaning at night and would not do it because they felt it was not their job to clean these things. <p>Interview with the Dietary Manager on 08/17/16 at 8:52 AM revealed:</p> <ul style="list-style-type: none"> -The Personal Care Aides and the Housekeeping staff were responsible for cleaning the dining rooms. -The Dietary Staff were responsible for cleaning the kitchen every day. -The dining rooms should be cleaned after every meal including sweeping, mopping, cleaning the table and chair. -The kitchen area was cleaned several times a day throughout the day by the kitchen staff. -He had already addressed with the Facility Manager about the bug issue in the kitchen and dining room. -He was told by management that a contracted exterminator would be called the same day that he notified them of the bug problem. -He had not seen anyone come in and spray the kitchen or dining room for bugs. <p>Interview with the Facility Manager on 08/17/16 at 10:50 AM revealed:</p> <ul style="list-style-type: none"> -Housekeeping was responsible for cleaning the dining room after breakfast and lunch. -Housekeeping leaves at 3PM so the Personal Care Aides were responsible for cleaning the dining rooms after dinner time. -The dining rooms should be cleaned after each meal and as needed. -The tables and chairs should be cleaned, the | D 282 | | |

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| D 282 | <p>Continued From page 62</p> <p>floors should be swept and mopped, they should make sure the trash has been taken out and the sinks are cleaned.</p> <p>-Housekeeping was responsible for cleaning the window seals in the dining room.</p> <p>-She was made aware a few days ago that there were roaches in the kitchen and dining room.</p> <p>-The Administrator went in and inspected the kitchen and found a box of beans and when he opened the lid there were several roaches crawling out of it and he disposed of the box.</p> <p>-The Administrator did call in a contracted exterminator who was scheduled to come in at night on 08/17/16 to spray the kitchen and dining room.</p> <p>Interview with the Administrator on 08/17/16 at 11:30 AM revealed:</p> <p>-The Personal Care Aides were responsible for assisting with cleaning the tables and chairs after each meal.</p> <p>-Housekeeping were responsible for cleaning up the rest of the dining rooms.</p> <p>-The Personal Care Aides were responsible for cleaning everything in the dining rooms after 3PM due to Housekeeping not working past 3PM.</p> <p>-The window seals should be cleaned daily by Housekeeping.</p> <p>-He had found a box of beans in the kitchen and when he opened them there were roaches all in the box; he immediately disposed of the box outside.</p> <p>-He had contacted an exterminator to come in and spray the kitchen and dining room.</p> <p>-The contracted exterminator was scheduled to come in on 08/17/16 at night to spray the kitchen and dining room.</p> <p>_____</p> <p>Review of the facility's plan of protection dated for</p> | D 282 | | |

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| D 282 | Continued From page 63 08/17/16 revealed: -The Dietary Manager is in training and will be responsible for ensuring that the kitchen and storage areas are cleaned. -He was hired on 08/12/16 and will be trained to ensure the facilities are clean and food ready. -The Dietary Manager will meet weekly with department leaders to address any facility or residents issues. -If any issues arise the Dietary Manager will be responsible for notifying the facility Administrator immediately. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2016. | D 282 | | |
| D 287 | 10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received a knife and spoon with their place setting for the last 6 months. The findings are: | D 287 | The facility shall provide at each meal for each resident a napkin, fork, spoon plate, knife and beverage containers. This will be monitored by the facility manager to ensure all residents have a full place setting and the Administrator weekly to ensure all residents needs and preferences are met. | 10/31/16 |

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RIVERVIEW

STREET ADDRESS, CITY, STATE, ZIP CODE
**3407 OAK ROAD
NEW BERN, NC 28563**

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| D 287 | <p>Continued From page 64</p> <p>Observations on 08/15/16 at 12:00 p.m. revealed none of the residents in the dining room were given a knife in their place setting during their lunch meal.</p> <p>Observations on 08/16/16 at 12:00 p.m. revealed none of the residents in the dining room were given a knife in their place setting during their lunch meal.</p> <p>1. Record review for Resident #1 revealed no documentation regarding the residents need or preference of place settings.</p> <p>Attempted interview with Resident #1 unsuccessful.</p> <p>Refer to interview with a Personal Care Aide on 08/16/16 at 12:05 p.m</p> <p>Refer to interview with Dietary Manager on 08/16/16 at 12:15 pm.</p> <p>Refer to interview with the Administrator on 08/16/16 at 2:30 p.m.</p> <p>2. Record review for Resident #2 revealed no documentation regarding the residents need or preference of place settings.</p> <p>Interview with Resident #2 on 08/16/16 at 2:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The residents had been eating with only a fork until this week. - He had to eat cereal for breakfast a lot of mornings with a fork. - He had asked for a spoon several times but was | D 287 | | |

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| D 287 | <p>Continued From page 65</p> <p>told by the staff to use his fork to eat the cereal and then drink the milk.</p> <p>Refer to interview with a Personal Care Aide on 08/16/16 at 12:05 p.m</p> <p>Refer to interview with Dietary Manager on 08/16/16 at 12:15 pm.</p> <p>Refer to interview with the Administrator on 08/16/16 at 2:30 p.m.</p> <p>3. Record review for Resident #3 revealed no documentation regarding the residents need o preference of place settings.</p> <p>Interview with Resident #3 on 08/16/16 at 2:20 p.m. revealed: - She was "tired of eating cereal and soup with a fork." - When meat was served, the residents had to "pick it up and bite it" because they did not have a knife to cut it up.</p> <p>Refer to interview with a Personal Care Aide on 08/16/16 at 12:05 p.m</p> <p>Refer to interview with Dietary Manager on 08/16/16 at 12:15 pm.</p> <p>Refer to interview with the Administrator on 08/16/16 at 2:30 p.m.</p> <p>4. Record review for Resident #4 revealed no documentation regarding the residents need or preference of place settings.</p> <p>Attempted interview with Resident #4</p> | D 287 | | |

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| D 287 | <p>Continued From page 66</p> <p>unsuccessful.</p> <p>5. Record review for Resident #6 revealed no documentation regarding the residents need o preference of place settings.</p> <p>Attempted interview with Resident #6 unsuccessful.</p> <p>Refer to interview with a Personal Care Aide on 08/16/16 at 12:05 p.m</p> <p>Refer to interview with Dietary Manager on 08/16/16 at 12:15 pm.</p> <p>Refer to interview with the Administrator on 08/16/16 at 2:30 p.m.</p> <p>_____</p> <p>Interview with a Personal Care Aide on 08/16/16 at 12:05 p.m. revealed:</p> <ul style="list-style-type: none"> - Residents had "never received a knife" in their place setting. - Residents "had not been receiving a spoon" in their place setting until the Administrator informed staff yesterday during lunch to add spoons to the place settings. -The residents had not had a knife or spoon in their place setting because the Facility Manager said the residents were stealing the utensils. - Residents were provided a spoon when they asked "if there were enough clean spoons available." - She did not know whether the facility had enough spoons and knives for all the residents. - The residents had frequently taken utensils from the place settings to their rooms so it was a waste of money to provide them with a fork, spoon and a knife. | D 287 | | |

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| D 287 | <p>Continued From page 67</p> <p>Interview with a Dietary Manager on 08/16/16 at 12:15 p.m. revealed: -He had been employed for two weeks. -The Facility Manager said residents were to get a spoon with their place settings after the county survey on 8/10/16. -He did not monitor if the residents had a fork, knife and spoon. -A resident could request any utensil if needed.</p> <p>Interview with the Administrator on 08/16/16 at 2:30 p.m. revealed: - Silverware had recently been purchased so there were plenty of forks, spoons, and knives for all the residents to have one. -The County's survey on 8/10/16 identified that residents were not receiving a spoon with their place setting. - He was not aware that residents were not being provided a knife with their place setting. - He had told the Personal Care Aides to make sure all residents were provided a fork, spoon, and knife at every meal. - The Personal Care Aides are responsible for ensuring residents have a complete place setting.</p> | D 287 | | |
| D 306 | <p>10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages.</p> <p>This Rule is not met as evidenced by:</p> | D 306 | | |

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| D 306 | <p>Continued From page 68</p> <p>Based on observations, interviews and record reviews, the facility failed to assure 48 of 48 residents were offered or served water along with their other beverage at meal times.</p> <p>The findings are:</p> <p>Observations on 08/15/16 at 12:00 p.m. revealed none of the residents were served water with their lunch meal.</p> <p>Observations on 08/16/16 at 12:00 p.m. revealed none of the residents were served water with their lunch meal.</p> <p>Interview with a Dietary Aide on 08/16/16 at 12:05 p.m. revealed:</p> <ul style="list-style-type: none"> - Residents were not served water because they did not like it and would only drink it if there was nothing else to drink. - The PCA was not aware if the residents had ever been asked if they liked water with their meals. - If a resident asked for water, then it would be served to them. - She was not aware that the residents were supposed to be served water with every meal. <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> - The resident had never been asked if he would like water or served water with his meal. - The resident had asked for and was served water when he was refused refills of tea about once a week. <p>Confidential interview with a second resident revealed:</p> <ul style="list-style-type: none"> - The resident had never been asked if she would like water or served water with her meal. | D 306 | | |

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| D 306 | Continued From page 69 - The resident had never asked for water during a meal. Interview with the Administrator on 08/16/16 at 2:30 p.m. revealed: - He was aware that residents are supposed to be served water with every meal. - The staff had been educated numerous times on the need to serve water at every meal. - He was not aware that the residents were not being offered or served water. - The Dietary Manager was responsible for ensuring that all residents received water with their meals but had just started employment two weeks ago so he probably did not know the rule. | D 306 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to serve therapeutic diets as ordered by a prescribing practitioner. Including diabetic diets and no added table salt diets not being served for 1 out of 5 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated for 06/08/16 revealed: | D 310 | The facility will train all dietary staff on the diets offered by the facility. The RCC + Facility manager will develop a list of all diets, including therapeutic and train all staff on each residents diet. The dietary manager will also be provided with a list of residents diets to ensure | 10/31/16 |

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| D 310 | <p>Continued From page 70</p> <p>-Diagnoses included Vascular Dementia, Type 2 Diabetes, and Schizoaffective Undifferentiated. -A Physician's order for a no concentrated sweet diet.</p> <p>Observation of breakfast served to Resident #3 on 08/17/16 at 8:18 AM revealed -The Resident being served French toast sticks and regular syrup. -The resident added the syrup to his French toast and ate 100%.</p> <p>Review of the facility's approved therapeutic diet menu on 08/17/16 revealed residents receiving a no concentrated sweets diet should be served sugar free beverages, gelatins, syrups, jelly, and sweeteners except when being served milk.</p> <p>Interview with the Dietary Manager on 08/17/16 at 8:52 AM revealed: -He started as the dietary manager on 08/15/16. -He did have some credentials for working in a kitchen but had never worked with serving therapeutic diets. -He had not received any formal training on serving therapeutic diets. -He was aware that some residents were to receive special diets, but was not sure how to serve these diets. -He thought that no concentrated sweets meant he was not allowed to use extra sugar or heavy syrups. -He thought no added salts diets meant they could not add salt to the food when they were preparing food.</p> <p>Interview with the Facility Manager on 08/17/16 at 10:50 AM revealed: -The dietary manager started working at the facility one week ago.</p> | D 310 | <p>All dietary staff are trained on the current residents diets and they are served as order. The dietary department has further been trained on how to serve each diet for each resident.</p> <p>The Facility Manager and RCC will monitor this daily and weekly to ensure all residents are served the diets that were ordered by their physician. Administrator will monitor as needed.</p> | 10/31/16 |

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| D 310 | Continued From page 71 -He had not received any formal training but has gotten some training on working in the kitchen. -He was trained on basics such as pureed foods and chopped foods but has not been trained thoroughly on the specific diets. Interview with the Administrator on 08/17/16 at 11:30 AM revealed: -The Dietary Manager did not start working at the facility until 08/15/16. -He had not had any formal training on serving therapeutic diets. -He had training on the different diets but has not been trained in serving the diets. -He was planning on doing training this week with the Dietary Manager but the state surveyors showed up for the annual inspection. | D 310 | | |
| D 317 | 10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. | D 317 | | |

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| D 317 | <p>Continued From page 72</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure a minimum of 14 hours of planned group activities were provided each week, that promoted socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills for the census residents currently living in the facility.</p> <p>The findings are:</p> <p>Interview with the Activity Director on 08/15/16 at 9:45 a.m. revealed: -She did not begin activities until after 10:00 a.m. because most of the residents did not get out of bed until at least 10:00 a.m. -The only activities offered on the assisted living side of the building were current events and Pokemon. -The Activity Director was unable to explain Pokemon other than "it is complicated". -The residents on the assisted living side had never wanted or asked to participate in activities.</p> <p>Interview with a Medication Aide on 08/15/16 at 10:05 a.m. revealed: -The Activity Director walked around outside and did stretches with the residents in the special care unit daily. -The Activity Director played bingo with the residents on the assisted living side once a week. -Once a month, all the residents in the special care unit were taken to the dining room in the assisted living side of the building and all the residents had a party.</p> <p>Interview with a Housekeeper on 08/15/16 at 10:25 a.m. revealed he had never seen anyone in the gazebo.</p> | D 317 | <p>The facility has hired a new Activity Director who is certified. The activity Director has been trained and inserviced on the rules for Activities to ensure that the program has a minimum of 14 hours of variety of planned group activities per week. The Activity Director will complete activity assessments on all residents as well as six month progress notes. The facility manager will complete weekly checks to ensure the Activity Program</p> | 10/31/16 |

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| D 317 | <p>Continued From page 73</p> <p>A confidential interview with a resident revealed: -"We play bingo once a week but that is it."</p> <p>A confidential interview with a second resident revealed: -"Bingo and a game with a ball" were the only activities that they were aware of. -The resident was not aware when activities were going on because "the calendar was never right".</p> <p>A confidential interview with a third resident revealed: -The residents were supposed to go shopping on the tenth of every month. -Most of the time they were not able to go because the van was being used for a medical appointment.</p> <p>A confidential interview with a forth resident revealed: -"There is not much to do except watch television or smoke."</p> <p>A confidential interview with a fifth resident revealed: -"We have a birthday party every month." -"We play bingo once a week."</p> <p>Review of August 2016 Activity Calendar revealed: -The week of July 31, 2016 through August 6, 2016 listed 30 hours of activities. -The week of August 7, 2016 through August 13, 2016 listed 30 hours of activities. -The week of August 14, 2016 through August 20, 2016 listed 30 hours of activities. -The week of August 21, 2016 through August 27, 2016 listed 30 hours of activities.</p> | D 317 | <p><i>is meeting the minimum 14 hour per week requirement as well as meeting residents needs and preferences</i></p> | 10/31/16 |

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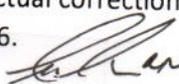
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| D 317 | <p>Continued From page 74</p> <p>Review of the August 2016 Activity Calendar for 8/15/16 revealed:</p> <ul style="list-style-type: none"> -Flex and stretch 9:00 a.m. - 9:30 a.m. 30 minutes. -Outside 9:30 a.m. - 10:00 a.m. 30 minutes. -Current events 10:00 a.m. - 10:30 a.m. 30 minutes. -Pokemon 10:30 a.m. - 11:10 a.m. 40 minutes. -Game 11:10 a.m. - 12:00 p.m. 50 minutes. -Gazebo time 12:50 p.m. - 1:10 p.m. 20 minutes. -Uno 1:10 p.m. - 2:00 p.m. 50 minutes. -Current events 2:00 p.m. - 2:30 p.m. 30 minutes. -Pokemon 2:30 p.m. - 3:30 p.m. 1 hour. -Music 3:30 p.m. - 4:00 p.m. 30 minutes <p>Observation on 08/15/16 at 9:40 a.m. revealed the Activity Director was standing in the front sitting area and no activities were being performed.</p> <p>Observation on 08/15/16 at 3:45 p.m. revealed no music activity on the assisted living side of the facility.</p> <p>Observation on 08/15/16 at 3:48 p.m. revealed no music activity on the special care unit.</p> <p>Interview with the Facility Manager on 8/15/16 at 9:55 a.m. revealed:</p> <ul style="list-style-type: none"> -She was aware that there were issues with activities. -They were going to have a new Activity Director begin next Monday. | D 317 | | |
| D 338 | <p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,</p> | D 338 | | |

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| D 338 | <p>Continued From page 75</p> <p>Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility neglected to notify the physician of aggressive behaviors . The findings are:</p> <p>Based on observation, interview, and record review the facility failed to assure that all residents in the facility were free of mental, physical abuse, neglect, and exploitation pertaining to the behaviors of Resident #5 and the prescribing practitioner not being notified of these behaviors.[Refer to Tag D273, 10 NCAC 13F .0902(b). (Type B Violation)].</p> | D 338 | <p>Addendum: Type B violation exceeds maximum correction date. Spoke with Administrator on 10/6/16. Actual correction date is: 10/1/16.</p>  | |
| D 358 | <p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered by a prescribing practitioner including a Spiriva inhaler being</p> | D 358 | | |

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| D 358 | <p>Continued From page 76</p> <p>omitted and not offered to a resident (Resident #7), and the prescribing practitioner not being notified per facility policy and procedure.</p> <p>The findings are:</p> <p>Review of Resident #7's current FL2 dated for 06/24/16 revealed: -Diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure, Seizure, a Left Closed Comminuted Displaced Impacted, history of alcohol abuse, Psychosis, Depression, Schizoaffective, and Tibial Plateau fracture. -A Physician's order for Spiriva (a bronchodilator to relax muscles in COPD patients) 18 micrograms Inhale contents of one capsule daily.</p> <p>Review of Resident #7's August 1-17 2016 Medication Administration Record (MAR) revealed: -There was an entry for Spiriva (a bronchodilator to relax muscles in COPD patients) 18 micrograms Inhale contents of one capsule daily. -There was documentation on the MAR that Resident #7 had refused to take her Spiriva on 08/13/16, 08/14/16, 08/15/16, and 08/16/16. -The Medication Aides had documented resident refused medication on all of these dates.</p> <p>Review of the facility's policy and procedure for medication administration revealed: -The primary care Physician shall be notified after three doses of refused medications. -Medications can only be withheld with a Physician's order.</p> <p>Review of Resident #7's Record revealed there was no documentation in the chart that Resident #7's primary care Physician had been notified</p> | D 358 | <p>The facility will always ensure that all medication technicians are properly trained on Medication Administration. All will be trained by the nurse from the pharmacy.</p> <p>The facility med-tech will offer all ordered medications to resident at the scheduled time, and afterwards document administrations and/or refusals. The residents prescribing practitioner will be notified by the med-tech after 3 consecutive refusals by the resident. This process will be monitored by the REC and facility manager daily, to ensure that residents receive medications as ordered and the physicians are notified. A resident aren't receiving meds as ordered.</p> <p>The Administrator will monitor as needed for issues</p> | 10/31/16 |

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| D 358 | <p>Continued From page 77</p> <p>about her refusing her Spiriva.</p> <p>Observation of the medication pass on 08/16/16 at 7:47 AM revealed: -Resident #7 did not receive her scheduled dose of Spiriva. -The Medication Aide did not offer Spiriva to Resident #7.</p> <p>Interview with a Medication Aide on 08/16/16 at 7:55 AM revealed: -Resident #7 refused her Spiriva every day. -The Medication Aides were to notify the Resident Care Coordinator (RCC) if a resident refused their medication and the RCC would notify the doctor.</p> <p>Interview with a Medication Aide on 8/17/16 at 12:00pm revealed: -She had 1 full week of training shadowing another medication aide prior to passing medications. -She had her medication aide certification for 1 year. -She was working PRN (as needed) at the facility until a month ago. -She was now full time as of a month ago. -She was supposed to log any resident refusals of medications. -If there was someone who refused medications more than 3 times, she was supposed to call the doctor.</p> <p>Interview with a second Medication Aide on 08/17/16 at 8:25 AM revealed: -He had been working at the facility for 3 years and trained a lot of the new medication aides. -He was trained prior to working at this facility to pass medications. -The medication aides should check the label on</p> | D 358 | | |

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| D 358 | <p>Continued From page 78</p> <p>the medication against the Medication Administration Record and if they do not match then they should check the order.</p> <p>-Each medication aide has to have a clinical skills checklist done by a Registered Nurse.</p> <p>Telephone interview with primary care Physician on 08/16/16 at 3:37 PM revealed:</p> <p>-The facility does fax her a copy of the medication that was refused and the dates when residents refuse medications.</p> <p>-She did not recall receiving any paperwork or phone calls that Resident #7 had been refusing her medications.</p> <p>-She expected the facility to notify her when a resident refused their medications.</p> <p>-Resident #7 was prescribed the Spiriva due to her history of Chronic Obstructive Pulmonary Disease.</p> <p>-Unless she had discontinued a medication then she expected the facility to continue to offer the medication when it was scheduled to be given even if the resident had been known to refuse medications.</p> <p>Interview with the Facility Manager on 08/17/16 at 10:50 AM revealed:</p> <p>-All Medication Aides were trained on the medication cart for several days before they can pass medications.</p> <p>-They were also signed off by a Registered Nurse for medication clinical skills before they can pass medications.</p> <p>-They also have to complete a 3 hour and 5 hour training on the pharmacy website prior to passing medications.</p> <p>-The facility's policy is that if a resident refuses a medications 3 or more days in a row they were to write down the dates and fax a copy to the medical doctor.</p> | D 358 | | |

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| D 358 | Continued From page 79 -It was expected that the Medication Aides offer all medication to each resident even if they normally refuse their medications. Interview with the Administrator on 08/17/16 at 11:30 AM revealed: -All Medication Aides have to get training done by the pharmacy to pass medications. -Medication aides were required to do 4 days of shadowing on the medication cart before they can pass medications. -All Medication Aides were required to do a clinical skills checklist with a Registered Nurse before they can pass medications. -If a resident refused any of their medications for 3 days in a row or more the Medication Aides should have notified the medical doctor per facility policy. -As long as the order for a medication is valid, the medication should be offered to a resident even if they have been refusing the medication. | D 358 | | |
| D 468 | 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. | D 468 | The facility has contracted with the pharmacy nurse that all current Special Care Unit Staff will be given the 20 hour training. All new staff will be given the 20 hour training by the nurse within 1 week of hire. This process will be monitored by the business office manager and the Reg. The facility manager will monitor this process | 10/21/16 |

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| D 468 | <p>Continued From page 80</p> <p>(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.</p> <p>(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.</p> <p>(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 2 of 4 sampled staff (Staff C and D) assigned to perform duties in the special care unit (SCU) received 6 hours of orientation training within the first week of employment, and 1 of 4 sampled staff (Staff D) received 20 hours of training within six months of employment. The findings are:</p> <p>1. Review of the personnel file for Staff C revealed: -Staff C was hired to work as a Medication Aide on 6/30/16. -There was documentation showing only 3 hours of SCU training. -There was no documentation of the required 6 hour SCU training in Staff C's personnel file.</p> <p>Attempted interview on 8/16/16 at 2:00pm with Staff C unsuccessful.</p> | D 468 | <p><i>to ensure that all staff working on the special care unit receive all necessary within the 1st week of employment.</i></p> <p><i>The Administrator will monitor this process monthly and as needed.</i></p> | 10/31/16 |

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| D 468 | <p>Continued From page 81</p> <p>Refer to the interview with the Administrator and Facility Manager on 8/16/16 at 2:15pm.</p> <p>2. Review of the personnel file for Staff D revealed: -Staff D was hired to work as Medication Aide on 11/6/13. -There was a certificate that Staff D had completed 2 hours of care of the geriatric patient training in May 2015. -There was no documentation of the required 6 hour or 20 hour SCU training in Staff D's personnel file.</p> <p>Refer to the interview with the Administrator and Facility Manager on 8/16/16 at 2:15pm.</p> <p>Interview with Staff D on 8/17/16 at 9:15am revealed the only training he had since starting to work at the facility was on the floor with another staff and some pharmacy-issued certificated.</p> <p>Refer to the interview with the Administrator and Facility Manager on 8/16/16 at 2:15pm.</p> <p>Interview with the Administrator and Facility Manager on 8/16/16 at 2:15pm revealed: -Staff received training during their first week of employment. -The staff worked with first shift staff on the floor which was considered to be their 6 hours of SCU training. -The facility nurse who was no longer employed here would have certified Staff D three years ago but the documentation must be missing. -The visiting nurse consultant was currently providing staff training and certificates. -He would ensure all staff had SCU training and proper documentation reflecting a 6 hour and 20</p> | D 468 | | |

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| D 468 | Continued From page 82 hour training certificate upon completion in each staff folder. | D 468 | | |
| 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 all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to staff tuberculosis testing, medication administration, and health care referral and follow-up. The findings are:</p> <p>1. Based on observations, record reviews and interviews, the facility failed to assure the home was maintained clean and free of all obstructions and hazards in residents' rooms and hallways as related to bed bugs, roaches, crickets, ants and wasps. [Refer to Tag D0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation).]</p> <p>2. Based on observations and interviews, the facility failed to assure the baseboards, walls, ceilings and floor coverings were kept clean and in good repair. [Refer to Tag D0074 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings (Type B Violation).]</p> | D912 | <p>The facility will train all employees on residents rights. It is the policy of the facility to always assure all residents receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>The facility will train and inservice: Housekeeping. The facility will have the Pest control operation perform weekly and monthly service calls for pest. The facility has hired a construction company to come in to replace and repair all needed baseboards, walls, ceilings and floor coverings are kept clean and in good repair. The facility has also hired a floor technician</p> | |

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| D912 | Continued From page 83 3. Based on observations and interviews, the facility failed to assure that each resident had clean bedspreads, clean sheets, clean pillows and cases. [Refer to Tag D0087 10A NCAC 13F .0306(b)(1) Housekeeping and Furnishings (Type B Violation).] 4. Based on observations, interviews, and record reviews, the facility failed to assure glucometers and strips were available and used on the correct patient. [Refer to Tag D0932 131D-4.4A ACH Infection Control (Type B Violation).] 5. Based on observation, interview, and record review the facility failed to keep food safe and protected from contamination. Including the kitchen and dining room having one or more roaches on the floors and walls, having cleaning chemicals stored with food, and not cleaning the floors and tables of the kitchen [Refer to Tag D287 Nutrition and Food Service (Type B Violation)]. | D912 | Who will clean, wax and buff all floors daily and maintain. The facility manager and Administrator will monitor this process daily to ensure that they remain clean and in good repair. The facility has purchased all new bedding to replace bedspreads, sheets, pillows and pillow cases to replace all damaged bedding. Staff will monitor resident bedding daily and change daily and as needed. This will be monitored by the facility manager and RCC weekly and by the Administrator as needed. | 10/31/16 <i>see addendum</i> |
| 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 | D932 | The facility has purchased all new glucometer and testing supplies for all residents. These supplies have been individually labeled and kept separately. All medication aides will receive diabetic training and infection control. | 10/31/16 <i>see addendum</i> |

Addendum: Type B violation exceeds maximum correction date. Spoke with Administrator on 10/6/16. Actual correction date is: 10/1/16.

[Signature]

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| D932 | <p>Continued From page 85</p> <p>stick blood sugars (FSBS).</p> <p>The findings are:</p> <p>A. Review of Resident #1's current FL-2 dated 04/08/16 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included Type 2 Diabetes, vascular dementia, and major depression. - No order for FSBS was included on the FL-2. <p>Review of Resident #1's Resident Register revealed an admission date of 12/05/14.</p> <p>Review of Resident #1's Vitals Report with entries from 07/18/16 through 8/16/16 revealed FSBS were documented four times daily.</p> <p>Interview with Resident #1 on 08/16/16 at 9:15 a.m. revealed:</p> <ul style="list-style-type: none"> - His FSBS had not been checked as ordered (four times daily). - There had been two times recently he did not get his FSBS checked as ordered. - He had asked for his FSBS to be checked at times other than when it was ordered but the Medication Aides refused. - The Medication Aides had told him they would run out of strips if they tested more than what was ordered. <p>Review of Resident #1's individually labeled glucometer history revealed:</p> <ul style="list-style-type: none"> - There were a total of 125 readings in the history between the dates of 07/18/16 and 8/16/16. - There were a total of 111 readings that correlated with the entries on the Vitals Report. - There were 7 entries on the Vitals Report between 07/19/16 and 8/14/16 that did not appear in the glucometer history. | D932 | <p>daily to ensure that the appropriate infection prevention requirements are met.</p> <p>The Administrator will monitor monthly to ensure this followed.</p> <p>The glucometer procedures will be reviewed with all medication technicians by the pharmacy nurse.</p> <p>Addendum: Type B violation exceeds maximum correction date. Spoke with Administrator on 10/6/16. Actual correction date is: 10/1/16.</p> <p><i>[Signature]</i></p> | <p>10/31/16</p> <p>See Addendum</p> |

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| D932 | <p>Continued From page 86</p> <p>Interview with a Medication Aide on 08/16/16 at 9:40 a.m. revealed:</p> <ul style="list-style-type: none"> - The individually labeled glucometer for resident #3 was probably used to check FSBS for resident #1 because of the similarities in their names. - Four readings (07/20/16, 07/21/16, 08/13/16, and 08/14/16) on the Vitals Report for Resident #1 were taken with Resident #3's glucometer. - The Medication Aide was not sure why there were 6 readings on Resident #1's glucometer history that were not documented. -She was able to explain the system of proper glucometer usage and disinfection technique of the glucometer and lancet device. <p>Telephone interview with Resident #1's primary physician on 08/16/16 at 10:50 a.m. revealed there was an order in place for the residents FSBS to be checked four times daily.</p> <p>Refer to interview with Administrator and Facility Manager on 08/16/16 at 11:35 a.m.</p> <p>B. Review of Resident #3's current FL-2 dated 04/08/16 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included Type 2 Diabetes, vascular dementia, and schizophrenia. - There was an order for FSBS to be checked twice daily. <p>Review of Resident #3's Resident Register revealed an admission date of 09/09/15.</p> <p>Review of Resident #3's Vitals Report with entries from 07/18/16 through 8/16/16 revealed FSBS were documented twice daily.</p> <p>Review of Resident #3's individually labeled glucometer history revealed:</p> <ul style="list-style-type: none"> - There were a total of 76 readings in the history | D932 | | |

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| D932 | <p>Continued From page 87</p> <p>between the dates of 07/18/16 and 8/16/16.</p> <ul style="list-style-type: none"> - There were a total of 48 readings that correlated with the entries on the Vitals Report. - There were 5 entries on the Vitals Report between 07/21/16 and 7/28/16 that were not found in the glucometer history. <p>Interview with a second Medication Aide on 08/16/16 at 10:05 a.m. revealed:</p> <ul style="list-style-type: none"> - There were 4 readings (7/21/16, 7/23/16, 8/6/16, and 8/15/16) that were taken with Resident #1's individually labeled glucometer rather than with Resident #3's glucometer. - There was 1 reading (8/8/16) that was taken with Resident #8's glucometer rather than with Resident #3's glucometer. - When shown the Resident #3's glucometer, the Medication Aide could not explain why there were 18 readings in the history of Resident #3's glucometer that were not recorded on the Vitals Report. <p>Refer to interview with Administrator and Facility Manager on 08/16/16 at 11:35 a.m.</p> <p>C. Review of Resident #8's current FL-2 dated 06/24/16 revealed:</p> <ul style="list-style-type: none"> - Diagnoses included Type 2 Diabetes, Alzheimer's dementia, cataracts, hyperlipidemia, hypertension, rectal bleeding, seborrheic dermatitis, and history of sepsis. - There was an order for FSBS to be checked daily. <p>Review of Resident #8's Resident Register revealed an admission date of 03/24/15.</p> <p>Review of Resident #8's Vitals Report with entries from 07/18/16 through 8/16/16 revealed FSBS were documented four times daily.</p> | D932 | | |

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| D932 | <p>Continued From page 88</p> <p>Review of Resident #8's individually labeled glucometer history revealed:</p> <ul style="list-style-type: none"> - There were a total of 86 readings in the history between the dates of 07/18/16 and 8/16/16. - There were a total of 84 readings that correlated with the entries on the Vitals Report. - There were 28 entries on the Vitals Report between 07/19/16 and 8/16/16 that were not found in the glucometer history. <p>Interview with a third Medication Aide on 08/16/16 at 10:35 a.m. revealed:</p> <ul style="list-style-type: none"> - Two readings (07/21/16 and 08/07/16) on the Vitals Report were taken using Resident #1's glucometer. - The Medication Aides had been recording the same FSBS reading for the second ordered check since the checks were only an hour apart. <p>Telephone interview with Resident #8's primary physician on 08/16/16 at 11:00 a.m. revealed there was a current order for the residents FSBS to be checked four times daily.</p> <p>Observation of both medication carts on 08/16/16 at 10:35 a.m. revealed:</p> <ul style="list-style-type: none"> -Each cart had a sufficient supply of lancet needles. -Each cart had glucometers for the 14 diabetic residents in the facility. -The assisted living side's med cart did not have disinfectant wipes available on the cart. <p>Review of the facility's Blood Glucose Monitoring Policy and Procedure revealed:</p> <ul style="list-style-type: none"> - "If the resident has a complaint consistent with signs and symptoms of hypo or hyper glycemc, obtain a blood sample." - "Cleanse the finger with alcohol prep." | D932 | | |

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| D932 | <p>Continued From page 89</p> <p>Telephone interview with a Medication Aide on 08/16/16 at 11:10 a.m. revealed:</p> <ul style="list-style-type: none"> - The Medication Aide does not always clean the resident's fingers before checking FSBS. - Prior to last month, a house glucometer was being used for all residents because there were no test strips for the resident's individually labeled glucometers. - Last month, all the residents received new glucometers and lancing devices. - The Medication Aide has caught himself grabbing random glucometers to check FSBS because that is what he got used to doing. - Glucometers were not cleaned after use. - He had found labeled lancing devices in the wrong labeled glucometer pouch on a couple of occasions during the past month. <p>Interview with the Administrator and Facility Manager on 08/16/16 at 11:35 a.m. revealed:</p> <ul style="list-style-type: none"> -They were made aware last month that a house glucometer was being used by the Medication Aides. -They had all the Medication Aides sign a procedures reminder before they were allowed to check FSBS. -Personal glucometers were purchased for all residents who did not currently have one. -Outdated or no longer used glucometers were discarded. <p>Review of Glucometer and Lancet Procedures letter from the Administrator on 08/16/16 which was signed by all Medication Aides revealed:</p> <ul style="list-style-type: none"> - "This is to remind you the importance of using one blood glucose meter per resident." - "The monitor and lancing device will be labeled to ensure the right resident to the right equipment." | D932 | | |

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| NAME OF PROVIDER OR SUPPLIER RIVERVIEW | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3407 OAK ROAD NEW BERN, NC 28563 | | |
| (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 | |
| D932 | <p>Continued From page 90</p> <p>- "At no time are you to use someone else's equipment on another resident as this could lead to a cross contamination issue."</p> <hr/> <p>Review of the facility's Plan of Protection dated 8/17/16 revealed: -The Administrator will educate all Medication Aides and ensure the use of personal glucometers on only said residents as of 8/17/16. -Glucometer strips will be available as of 8/17/16 for all residents.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 1, 2016.</p> | D932 | | | |