| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **345520** | A. BUILDING _____ B. WING _____ | **08/27/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PELICAN HEALTH THOMASVILLE** | **1028 BLAIR STREET THOMASVILLE, NC 27360** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0584<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Some | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations and staff interviews, the facility failed to maintain a clean and safe environment by failure to keep over the bed lighting free of dust build up and maintain intact sheetrock for one of one resident room (room [ROOM NUMBER]B) and maintain a clean and sanitary shower for one of one shower room (200 hall shower), reviewed for environment. Findings included: 1. An interview was conducted with Resident #3 on 8/25/20 at 9:00 AM. During the interview the resident stated how he felt the shower room on the 200 hall side was filthy and he hated to take a shower in it. The resident further stated the shower room was never cleaned. The resident said he had recently taken a shower and there were dirty towels on the floor in addition to the general overall lack of cleaning in the shower. An observation was conducted on 8/25/20 at 9:02 AM of the 200 hall shower room. The observation revealed 2 towels on the floor. The tile walls had visible a visible dark matter on the tile and grout surface near the floor of the shower. Peeling paint was observed around the window casing in the shower. There was a buildup of dust on both ceiling mounted exhaust fans. There were multiple unsealed gaps from where the mortared back of the tiles could be observed around the window and door. An observation was conducted of the 200 Hall shower room on 8/25/20 at 5:43 PM. The observation revealed 3 bath towels on the floor, 1 appearing wet and 2 appearing dry. An additional towel was observed hanging over the back of a rolling [MEDICATION NAME] Chloride (PVC) shower chair. There was a trash can with no liner, 5 disposable gloves and part of a vacuum cleaner hose in the trash can. The tile walls had visible a visible dark matter on the tile and grout surface near the floor of the shower. Peeling paint was observed around the window casing in the shower. There was a buildup of dust on both ceiling mounted exhaust fans. There were multiple unsealed gaps from where the mortared back of the tiles could be observed around the window and door. An interview was conducted with Resident #3 on 8/25/20 at 5:59 PM. The resident stated the shower rooms were routinely dirty and untidy. He said the shower needed to be cleaned and kept clean. He also pointed out the missing cove base to the right of the shower room door in the hallway. He further pointed out that was just one example of several construction issues he had observed throughout the facility. Observations were conducted in conjunction with an interview with the administrator on 8/25/20 which started at 6:11 PM. The administrator stated the shower room was cleaned by both housekeeping and nursing. During an observation of the shower room, the administrator stated the shower room did not appear to have been clean nor cleaned. The observation revealed 3 bath towels on the floor, 1 appearing wet and 2 appearing dry. An additional towel was observed hanging over the back of a rolling [MEDICATION NAME] Chloride (PVC) shower chair. There was a trash can with no liner, 5 disposable gloves and part of a vacuum cleaner hose in the trash can. The tile walls had visible a visible dark matter on the tile and grout surface near the floor of the shower. Peeling paint was observed around the window casing in the shower. There was a buildup of dust on both ceiling mounted exhaust fans. There were multiple unsealed gaps from where the mortared back of the tiles could be observed around the window and door. The administrator stated it was his expectation for the shower to have been kept clean and cleaned after each shower had been completed. Upon exiting the shower the missing cove base in the hallway to the right of the shower door was observed and the administrator stated the maintenance director had only been at the facility for about a week and both he and the maintenance director were aware of construction concerns which needed attention at the facility. The administrator stated both he and the maintenance director were working on a list of construction concerns for the building and were working on resolving the concerns. 2. During an observation of the environment in room [ROOM NUMBER], B bed, conducted on 8/25/20 at 11:51 AM, a hole was observed behind the bed on the right side of the bed. The hole was 1-2 inches wide and 4-6 inches tall. The hole went through the sheetrock and the inside of the wall could be visualized through the hole. Further observation revealed a buildup of dust on the over the bed light which was stuck to a paper towel when the area was wiped. During an observation of the environment in room [ROOM NUMBER], B bed, conducted on 8/25/20 at 5:54 PM, a hole was observed behind the bed on the right side of the bed. The hole was 1-2 inches wide and 4-6 inches tall. The hole went through the sheetrock and the inside of the wall could be visualized through the hole. Further observation revealed a buildup of dust on the over the bed light which was stuck to a paper towel when the area was wiped. Observations were conducted in conjunction with an interview with the administrator on 8/25/20 which started at 6:11 PM. The administrator stated the maintenance director had only been at the facility for about a week and both he and the maintenance director were aware of construction concerns which needed attention at the facility. During an observation of room [ROOM NUMBER]B a hole was observed behind the bed on the right side of the bed. The hole was 1-2 inches wide and 4-6 inches tall. The hole went through the sheetrock and the inside of the wall could be visualized through the hole. Further observation revealed a buildup of dust on the over the bed light which was stuck to a paper towel when the area was wiped. The administrator stated both he and the maintenance director were working on a list of construction concerns for the building and were working on resolving the concerns. The administrator also explained it was his expectation for high dusting to be completed as part of routine room cleaning. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br><br>Based on observations and staff interviews, the facility failed to maintain a safe environment by failure to keep chemicals secured and failure to empty an overflowing sharps container for one of one shower room (200 hall shower), reviewed for safety. Findings included: An observation was conducted on 8/25/20 at 9:02 AM and 5:43 PM of the unlocked 200 hall shower room. The observation revealed an unlocked wall cabinet with a loose door which hung ajar. Further observation revealed the contents inside of the unlocked cabinet included shampoo, body wash, and other assorted toiletries. Inside of the cabinet an unlocked padlock was observed to have been sitting in a soap like liquid substance and was showing some signs of corrosion. An observation of the wall mounted sharps container (a plastic container utilized to dispose of sharp objects in a health care setting, such as needles, lancets, disposable razors) revealed it to have contents within it above the designated fill line and was so full there were 6-8 handles of used disposable razors sticking out of the top of the sharps container. During a phone interview conducted on 8/26/20 at 4:34 PM with Nursing Assistant (NA) #1 she stated she had assisted residents with showers in the 200 hall shower room. The NA explained she had seen the cabinet in the shower room locked, but she did not know who had a key. She said she did not have a key to remove the sharps container from the wall bracket. She said if she were to see the sharps container was becoming full, she would notify one of the nurses from the 200 hall. An observation was conducted in conjunction with an interview with the administrator on 8/25/20 which started at 6:11 PM of the unlocked shower room on the 200 hall side of the building. The administrator stated the shower room was |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 345520 | A. BUILDING _____ B. WING _____ | 08/27/2020 |

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>cleaned by both housekeeping and nursing. The observation revealed an unlocked wall cabinet with a loose door which hung ajar. Further observation revealed the contents inside of the unlocked cabinet included shampoo, body wash, and other assorted toiletries. Inside of the cabinet an unlocked padlock was observed to have been sitting in a soap like liquid substance and was showing some signs of corrosion. The administrator stated the soaps, shampoos, and other toiletries in the cabinet should be locked or secured. An observation of the wall mounted sharps container revealed it to have contents within it above the designated fill line and was so full there were 6-8 handles of used disposable razors sticking out of the top of the sharps container. The administrator stated the sharps container was full and should have been removed from the bracket on the wall, disposed of, and replaced with an empty sharps container. The administrator stated there were no wondering residents in the area of the 200 hall shower and it was an area where staff members frequently passed. He further stated if a resident were to have wondered in that area, it was also visible from the nurses ' station and the resident would have been redirected. |
| F 0925<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review, observations, and staff interviews, the facility failed to maintain an effective pest control program for one of one shower room (200 side shower room), and five of five resident rooms 203, 205, 206, 207 and 220) reviewed for insect presence. Findings included: Pest control Customer Service Reports from the pest control service were reviewed for the following dates of: 2/28/20, 3/30/20, 5/14/20, 5/20/20, 6/5/20, 6/11/20, 7/27/20, 8/10/20, and 8/25/20. The following recommendations were documented on the reports from: 2/28/20, 3/30/20, 5/14/20, 5/20/20, 6/5/20, 6/11/20, 7/27/20, 8/10/20, and 8/25/20: The floor tiles or baseboards were found to be loose or missing in the interior and resident rooms. The documented action needed was to please repair to eliminate potential pest harborage/breeding sites. Also, the reports dated 2/28/20, 3/30/20, 5/14/20, and 5/20/20 detailed the rear exit door was found to be open and it would be an entry point to allow rodents and flies into the facility. The recommendation was to remind employees to keep the door closed, to install a screen door, or an automatic door closer. Further review of the 2/28/20, 5/14/20, 5/20/20, 6/5/20, 6/11/20, 8/10/20, and 8/25/20 reports revealed documentation of a finding the building was aged and there were many structural issues, including under every sink in the resident rooms needed to be sealed better and there were baseboards peeling off of the wall in a lot of areas around the building. The report had a finding of roaches noted in room [ROOM NUMBER] during service visits on 5/14/20 and 5/20/20 and in the kitchen during service provided on 7/27/20. An interview was conducted with Housekeeper #1 on 8/25/20 at 9:08 AM. During the interview she stated she had been working at the facility for about a month. She stated there were some resident rooms where she had observed what she had believed to have been roaches. She said she would see the insects in resident rooms about once a week. She said she had seen an exterminator come to the facility and spray since she had started. The housekeeper further stated when she had seen an insect, she would squash it, kill it, and then tell her supervisor. During an observation of medication administration by Nurse #1 in room [ROOM NUMBER] at 10:00 AM on 8/25/20, a reddish brown colored roach was observed crawling up the privacy curtain. During an interview Nurse #1 stated the insect on the privacy curtain was a roach. The nurse was observed to take a paper towel and killed the insect. The nurse further stated she saw roaches everywhere, even when the facility had been sprayed for insects. An interview was conducted at 10:05 AM on 8/25/20 with Resident #2. The resident stated he frequently saw roaches in his room. He also said he had seen roaches in the common area and in the hallway between the two sections of the building. An observation was conducted at 11:14 AM on 8/25/20 at 11:14 AM of room [ROOM NUMBER]. There were 9 dead roaches observed on the floor of the bathroom. Inspection of the ceiling mounted smoke detector revealed a live nymph (young) roach. There was also what appeared to be roach feces on the toilet paper dispenser. An observation of room [ROOM NUMBER] conducted at 11:25 AM on 8/25/20 revealed numerous dead roaches on the floor of the room and on the floor of the bathroom for the room. At least 4 roaches were observed on the top of installation bracket on the right side of the mini blinds mounted to the window casing for the window on the right side of the room. An observation of the window on the left side of the room revealed at least 4 roaches were observed on the top of installation bracket on the right side of the mini blinds mounted to the window casing for the window. For each window when the valance was tapped the roaches would move about in the space between the installation bracket and the window casing. Under the window on the left side of the window two roaches were observed to be moving back and forth from a crack in the tile under the cove base. When the nightstand was moved by the window on the left side of the room a roach was observed to be moving under the displaced nightstand. Two more roaches were observed to be moving in the cabinet under the vanity sink. When the vanity was knocked on, another roach was observed to be crawling out of the left side between the vanity and the floor. An observation of the bathroom revealed when the plastic bag wrapped toilet plunger was moved a nymph roach was crawling on the floor. During an interview with Housekeeper #2 on 8/25/20 at 11:38 AM she stated she saw roaches in resident rooms every day and she had seen large and small roaches. She stated she had been working at the facility for about a month. She said she had seen roaches in room [ROOM NUMBER] and 205. The housekeeper explained when she saw them, she killed them, then would tell her supervisor, and then the exterminator would be called. She said she had seen the exterminator at the facility three times since she had started. The housekeeper then did an observation of room [ROOM NUMBER] and she said there were live roaches in the room, and she stepped on the one she saw crawling on the floor. She said the room was vacant at the time and it had to be cleaned. She said the residents who had been in that room had been moved to the room next door. She believed the residents had just been moved in the past day or two and the room had to be detailed. An interview with the Maintenance Director (MD) was conducted in conjunction with an observation of room [ROOM NUMBER] on 8/25/20 at 12:08 PM. The MD stated he had started at the facility about a week ago and he had not seen roaches at the facility. During the observation of room [ROOM NUMBER] at least 4 roaches were observed on the top of installation bracket on the right side of the mini blinds mounted to the window casing for the window on the right side of the room. An observation of the window on the left side of the room revealed at least 4 roaches were observed on the top of installation bracket on the right side of the mini blinds mounted to the window casing for the window. For each window when the valance was tapped the roaches would move about in the space between the installation bracket and the window casing. When the nightstand for the bed next to the window on the left side of the room was moved a nymph roach was observed to be crawling on the floor. Four-Five nymph roaches were observed crawling on the floor when the toilet plunger as moved in the bathroom. Another roach was observed crawling in and out from under the left side of the sink vanity in the room. Multiple dead roaches were observed on the floor throughout the room. The MD stated he was going to contact the exterminator to inform them of the observed roaches in the room. During an interview conducted on 8/25/20 at 12:19 PM with the administrator he stated the exterminator was coming into the facility on a regular basis to spray the rooms and they also had some rooms fumigated for roaches. The administrator stated in addition to spraying for insects or roaches in the facility, they were also trying to keep residents from hoarding food, which also had been attracting pests. The administrator further explained they had also had occurrences when residents had been admitted and some of their belongings were discovered to have had roaches in them. He said they have had times when they had fumigated two rooms which were next to each other because they found if they fumigated one room, the roaches often would be found in the adjacent room after fumigation. The administrator participated in an observation of room [ROOM NUMBER] and 4-5 nymph roaches were observed in the bathroom and appeared to have been coming out from under a broken piece of floor tile in the bathroom. The administrator explained he was going to have rooms [ROOM NUMBER] fumigated for roaches. At least 4 roaches were observed on the top of installation bracket on the right side of the mini blinds mounted to the window casing for the window on the right side of the room. An observation of the window on the left side of the room revealed at least 4 roaches were observed on the top of installation bracket on the right side of the mini blinds mounted to the window casing for the window. For each window when the valance was tapped the roaches would move about in the space between the installation bracket and the window casing. An interview was conducted on 8/25/20 at 3:29 PM with the exterminator in conjunction with an observation of rooms 203, 205, 206, and 207 in the presence of the MD. The observation revealed a roach in the bathroom of room [ROOM NUMBER], multiple roaches and nymphs in the bathroom and room of 205, and in rooms [ROOM NUMBERS]. The exterminator informed the MD there were multiple areas in each room where an application of a silicone sealant would help to eliminate places of insect harborage or an area where food and debris may become lodged, which would provide a food source for insects. The exterminator explained roaches liked to get underneath walls, tiles, cove base, and other small areas. The exterminator further explained roaches like to get under broken tiles, such as were |

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| F 0925<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>observed in the bathroom of room [ROOM NUMBER], in the small place where the tile was loose, and they would eat the adhesive which was used to apply the tile, he added they would also eat the glue behind the cove base. The exterminator said he had been working with the facility regarding pest control in several rooms and he believed rooms [ROOM NUMBER] needed to be fumigated. An interview was conducted with the contracted exterminator on 8/25/20 at 4:42 PM. He stated construction concerns which he listed on his Customer Service Reports, such as repairing baseboards and loose floor tiles, had not been addressed through his observations during repeat visits. He stated he had made several visits to the facility in the current year and was their assigned exterminator. The exterminator explained the facility had German roaches. He stated roaches and other insects liked to get in around loose baseboard at the bottom of the wall. He stated unless the baseboard was sealed to the wall or the floor, even the smallest and thinnest opening, created an area where roaches and other insects could live and breed. He also stated the open areas created an opening where food and other edible debris could get into the openings and were not easily cleanable. The exterminator further stated the broken floor tiles also created an area where roaches liked to live and breed. He said the roaches would get under the loose or broken tiles and eat the glue which was holding the tiles down and food, debris, and moisture would get trapped under the loose tiles making a preferable habitat for roaches. The exterminator explained he was currently working with the facility to fumigate rooms which were discovered to have been problem areas, but unless the facility started to address the structural issues, it made it very difficult to fully manage the pest control. During an observation of the 200 Hall shower room conducted on 8/25/20 at 5:43 PM a roach was discovered crawling on the floor on the floor when the linen hamper was moved. Two spiders and their webs were observed near the floor under the cabinet. An earwig was observed crawling on the floor when a barrel type of bin was moved. An observation of room [ROOM NUMBER] was conducted in conjunction with an interview with the administrator at 6:11 PM on 8/25/20. The administrator stated the current MD had only been at the facility for a week and he was working and would continue to work on the identified construction concerns which yielded areas for insect harborage. Multiple roaches were observed throughout the room during the observation. The administrator further stated he would continue to work with the exterminator to address rooms [ROOM NUMBER] with fumigation and other rooms as needed. |