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D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation on 09/17/19 through 09/20/19 and 09/23/19 through 09/25/19 with an exit conference via telephone on 09/26/19.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure walls, ceilings and floors in the special care unit (SCU) were kept clean and in good repair as evidenced by a missing threshold saddle on the floor of a resident bathroom, warped linoleum in a resident bathroom and thick dirt accumulation at the edges and in corners of floors, and dirt build up and stickiness on floors in resident rooms, bathrooms and hallways on the SCU. Observations on the Special Care Unit (SCU) on 09/17/19 from 9:29am until 10:41am revealed: -There was a missing threshold saddle at the bathroom door in room 40 and warped linoleum on the floor inside the bathroom. -There was an electrical outlet loose and ajar from the wall approximately one quarter inch in	D 074		

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room 46.
-The floor was sticky in room #50.
-There was a missing electrical outlet on the wall between the beds in room 53.
-There was a cracked electrical outlet on the wall by the mirror in the shared bathroom in room 53.
-There was dirt build up and grime accumulation along the edges and in the corners of the hallways, linen closet, shared bathrooms and resident rooms 38, 39, 40, 42, 44, 46, 48, 50 and 53.

Interview with a personal care aide (PCA) on 09/18/19 at 10:52am revealed:
-She had noticed some things in need of repair and cleaning on the SCU; she could not think of any specific examples.
-She had not seen any deep cleaning done on the SCU.
-When staff noticed something in need of repair, they were supposed to write it on the maintenance sheet kept on the Assisted Living (AL) side.
-She had never written any repair concerns on the maintenance sheet.

Interview with the Maintenance Director on 09/20/19 at 2:33pm revealed:
-He was first made aware of the needed repairs on the SCU on 09/20/19.
-He had completed the repairs in room 53 and was working on room 46.
-He was at the facility one day per week to make repairs.
-He used to supervise the housekeeping staff, but he no longer did that since he was only in the facility one day a week.
-It had been approximately three months since he had supervised the housekeeping staff.

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D 074	Continued From page 2 Interview with the SCU Director on 09/18/19 at 3:08pm revealed: -Housekeeping staff were supposed to deep clean all the resident rooms every Wednesday. -Housekeeping staff were expected to pull furniture away from the walls and clean behind it with deep cleaning. -He did not know about the dirt and grime accumulation along the edges and in the corners on the floors in the SCU. -He did not know about the missing saddle threshold, warped linoleum in room 40 and broken/missing electrical outlets in rooms 46 and 53. -There was a maintenance log kept in the front office on the AL side that housekeeping and direct care staff could document maintenance concerns. -The Maintenance Director checked the log every Friday and two Wednesdays per month when he was at the facility. -The SCU was difficult to keep clean and in good repair because there were frequent messes and residents tended to break things. -The Maintenance Director was responsible for supervising housekeeping staff. -Any member of management made periodic checks of the environment on the SCU to make sure housekeeping staff were cleaning to facility standard and policy. -Management staff included the SCU Director, Activities Director (AD) and the Administrator. -He and the Administrator did daily walk throughs of the SCU prior to July 2019; since then he had done monthly walk throughs due to the facility being short staffed.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings	D 079		

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D 079	Continued From page 3 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Noncompliance continues with increased severity resulting in detriment to the health, safety and welfare of residents. THIS IS A TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure the facility was free of hazards as evidence by live roach activity in the kitchen, dining room and a shared residents bathroom; a helium cylinder, artificial decorative grass, sharpened coloring pencils, food and beverages left unsecured and accessible to residents on the Special Care Unit (SCU). The findings are: 1. Observation of the kitchen on 09/19/19 at 10:04pm revealed: -There was one small roach crawling on the floor in a corner near the entrance door to the kitchen. -The door to the kitchen was unlocked and the lights were off. -After the lights were turned on, there were 10 small roaches crawling on the floor close to the	D 079		

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D 079	Continued From page 4 dry pantry and prep tables of the kitchen. Interview with a cook on 09/20/19 at 2:00pm revealed: -In the past year the facility had issues with flies and mosquitos. -He had not noticed any roaches in the kitchen. -The kitchen staff was not given specific instructions from management on what to do if they saw a roach in the kitchen. -He would let the Dietary Manager (DM), the Administrator, or the maintenance man know if he saw any roaches in the kitchen and dispose of the roach. Interview with a second cook on 09/20/19 at 2:05pm revealed: -He did not see any roaches in the kitchen since December 2018. -An exterminator came to the facility to spray insect killer once every two weeks; he did not remember the last time he saw the exterminator. -The kitchen staff made sure the food was sealed up tight before they left for the night to reduce the risk of roaches getting into the kitchen. Confidential interview with staff revealed: -The staff saw roaches, especially in the kitchen every time the lights were turned on in the kitchen. -When the lights were turned on in the kitchen, they saw roaches of all sizes start to scatter. -The staff had not seen any roaches crawling in the food or on the countertops of the kitchen. -Since the staff had worked at the facility there had been issues with roaches in the kitchen but the staff thought the roach problem was getting worse. -The staff last saw the contracted pest control provider place a "gel" down approximately 1 ½ to	D 079		

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2 weeks ago to treat for roaches.
-The the DM or management had not told staff what to do if they saw roaches but, was told not to use any insecticidal sprays and to let the contracted pest control provider treat them.
-The staff had told the DM the roaches were "bad" but the DM told the staff to let the "exterminator" handle it.

Observations on the Special Care Unit (SCU) on 09/17/19 at 10:01am revealed:
-There were three live roaches (one baby, one small and one medium) on the floor in the shared bathroom in room #53.
-There were two dead adult roaches in the cabinet under the sink in the shared bathroom in room #53.

Interview with a housekeeper on 09/20/19 at 11:12 am revealed:
-She had seen insects in the building in the past, she did not know exactly when she saw them.
-She had seen the exterminator spraying in the past, she could not remember when or how often.

Interview with a second resident's family member on 09/20/19 at 11:37am revealed she had seen roaches in the building in the past.

Review of the facility's contracted pest control service report dated 03/15/19 revealed:
-There were two types of treatment for "German Cockroaches".
-The areas treated in the facility were identified with numbering codes as follows: #1 - kitchen and #3 - bathrooms with a compressed sprayer. A bait applicator was also used in the kitchen.
-In the comment section, there was a handwritten entry that included general pest 100% controlled.

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D 079	Continued From page 6	D 079		

Review of the facility's contracted pest control service report dated 07/09/19 revealed:
-There were two types of treatment for "German Cockroaches".
-The areas treated in the facility were identified with numbering codes as follows: #1 - kitchen, #3 - bathrooms and #5 - dining room with a compressed sprayer. A bait applicator was also used in the kitchen.
-In the comment section, there was a handwritten entry that included maintenance was completed, room #1 "tech" discovered live activity.

Review of the facility's contracted pest control service report dated 09/11/19 revealed:
-There were two treatments for "German Cockroaches".
-The areas treated in the facility were identified with numbering codes as follows: #1 - kitchen, #3 - bathrooms and #5 - dining room with a compressed sprayer. A bait applicator was also used in the kitchen.
-In the comment section, there was a handwritten entry that included maintenance was completed, room #1 "tech" discovered live activity.

Telephone interview with the pest control technician on 09/26/19 at 4:36pm revealed:
-He last serviced the facility on 09/14/19 for roaches.
-Staff had reported issues with roaches in the kitchen area.
-The facility was contracted for monthly visits.
-The contract did not include additional or on call visits, but the facility was able to call if there were concerns between monthly visits.

Interview with the SCU Director on 09/20/19 at 11:58am revealed:
-He was not aware of any pest problems, but the

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facility had roach activity in the dining areas, kitchen and pantry.
-The facility had a contracted pest control provider that treated the facility monthly.
-The facility used "good housekeeping practice" and staff were instructed not to leave food out to feed the pests.
-He was not sure if staff had been giving instructions on how or when to report when roach activity was seen; the Administrator or the DM handled that.
-He saw roaches in the facility Sunday, 09/15/19 but the pest control provider had just been out within the past 48-72 hours.

2. Observation of the family room on the Special Care Unit (SCU) on 09/19/19 at 4:56pm - 5:10pm revealed:
-The entrance door was opened and unlocked.
-There was a bag labeled with a fast food restaurant logo containing packaged food, a disposable cup with a lid sipper containing a liquid beverage, a second disposable plastic cup with a straw containing a pink colored beverage, an opened large can of a named brand soda sitting on a table positioned on the right side of the room.
-There were personal items including bags and clothing sitting on the furniture in the family room.
-There were staff in the hallway going in and out of different rooms, assisting the residents.

Interview with the Activity Director (AD) on 09/19/19 at 5:10pm revealed the food and beverage items stored in the family room belonged to staff.

Interview with a medication aide (MA) on 09/19/19 at 5:23pm revealed:
-The door to the family room "is usually always

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locked".
-The food bag belonged to her.
-The door was unlocked when she placed her bag of food in there about "3:30pm".
-She thought the door to the family room had been unlocked since 3:30pm.
-She did not have a key to the family room.

Review of the facility' therapeutic diet list for the SCU revealed there were four residents residing in the SCU listed with specific diets and modifications that included ground meats, pureed foods and thickened liquids.

Interview with a personal care aide (PCA) on 09/19/19 at 5:28pm revealed:
-The door to the family room was locked "sometimes".
-She started her shift today at 7:00am.
-She had placed her personal bag down in the room after she arrived at 7:00am today.

Interview with the Special Care Unit (SCU) Director on 09/19/19 at 5:45pm revealed:
-The family room on the SCU was used for residents' families when they visited.
-The family room should remain locked when not in use.
-The keys to the family room should be kept by the supervisor.
-He was concerned if items were left in the family room unsecured including the beverages and food around residents in the SCU because there was a resident on the SCU on thickened liquids and pureed foods.
-The supervisor would have been responsible to assure the door was locked to family room.

A second interview with the SCU Director on 09/20/19 at 11:58am revealed:

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D 079	Continued From page 9 -Staff had a designated area to store their personal belongings when they reported to work and those items should not have been stored in the family room on the SCU. -He performed walk-throughs on the SCU and looked for hazards such as shoes not tied or anything that could be a trip hazard. -He was not aware of a policy for hazards for the facility. 3. Observation of the family room on the Special Care Unit (SCU) on 09/19/19 at 4:56pm - 5:10pm revealed: -The entrance door was opened and unlocked. -There were several coloring pencils with a sharpened end in an opened plastic container stored on a table positioned on the right side of the room. -There were multiple, thin, long strands of green artificial grass (too numerous to count) stored in a second plastic bin with coloring books and miscellaneous paper type decorative wall items stored on a table positioned on the right side of the room. -There was a pink helium cylinder labeled with manufacturer's instructions stored on the floor, underneath the table on the right side of the room. -The cylinder was labeled with net contents of "8.9ft3" mixture of helium and air containing not less than 80% of helium. -There was a section labeled as "DANGER", do not place the nozzle in the mouth or nose for any reason; doing so could damage the lungs and other body parts, which could result in serious personal injury or death. -In the section labeled "DANGER" there were instructions that included the cylinder contained compressed helium under pressure, do not inhale helium and use in well ventilated areas - helium	D 079		

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reduced and could eliminate oxygen available for breathing. Inhaling helium could result in serious personal injury or death.
-There were staff in the hallway going in and out of different rooms, assisting the residents.

Observation of the Activity Director (AD) in the family room of the SCU on 09/19/19 at 5:10pm revealed:
-The AD picked up the pink colored helium cylinder and depressed the nozzle.
-No sound or pressure from the cylinder was observed.

Interview with the AD on 09/19/19 at 5:10pm revealed:
-The pink helium tank was empty, but she had "no idea" where it came from or who had placed the helium cylinder in the family room.
-She knew the helium tank was empty because when the nozzle was pressed nothing was expelled from the cylinder.
-The cylinder should not have been left in the family room.
-The sharpened colored pencils in the opened container should not have been left in the family room unsecured with the door opened.
-It was not safe to leave the sharpened colored pens unsecured on the SCU because residents could possibly "attack each other" or hurt themselves if staff were not there to monitor the residents.
-The green artificial grass should not have been stored in an unsecured area because the residents on the SCU could swallow the grass.
-The pencils and decorative grass could have been donated items and she would immediately secure the items.

Confidential interview with a staff member

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revealed:
-A female resident jabbed a male resident with the pointy end of a silver spoon at lunch time.
-Staff had tried to stop the female resident from jabbing the male resident.
-The female resident walked around in a circle to jab anyone that had tried to touch her.
-The management team was aware of this accident.
-The female resident was no longer able to use silverware; she had to use plastic cutlery.

Interview with a personal care aide (PCA) on 09/19/19 at 5:28pm revealed:
-The door to the family room was locked "sometimes".
-She started her shift today (09/19/19) at 7:00am.
-She had placed her personal bag down in the room after she arrived at 7:00am today (09/19/19).
-She thought the helium tank had been stored in the family room for "about one week maybe" but she did not pay attention to it.
-She did not know if the tank was empty because she did not pay any attention to it.
-She remembered seeing the decorative grass stored on the table in the family room for "about a week".

Interview with the Special Care Unit (SCU) Director on 09/19/19 at 5:45pm revealed:
-The family room on the SCU was used for residents' families when they visited.
-The family room should remain locked when not in use.
-The keys to the family room should be kept by the supervisor.
-He was not aware there was a helium tank, sharpened pencils and artificial, decorative grass was stored in the family room in the SCU.

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D 079	Continued From page 12 -He was concerned if items were left in the family room unsecured including the possibility of helium being available to residents. -He thought the decorative items left in the unlocked family room posed a choking hazard for the residents on the SCU. -The supervisor would have been responsible to assure the door was locked to family room. A second interview with the SCU Director on 09/20/19 at 11:58am revealed: -He performed walk-throughs on the SCU and looked for safety hazards such as shoes not tied or anything that could be a trip hazard. -He was not aware of a policy for hazards for the facility. _____ The facility failed to assure the environment on the special care unit (SCU) was free of hazards including roaches in food preparation areas for all residents which increases the risk for the residents to contract disease from an insect known to carry the risk of disease causing germs and health hazards. The facility's failure to assure an environment free of hazards was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/20/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 079		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio	D 234		

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D 234	Continued From page 13 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Noncompliance continues with increased severity resulting in detriment to the health, safety and welfare of residents. THIS IS A TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure 4 of 6 sampled residents (#2, #3, #5 and #14) had completed tuberculosis testing upon admission according to control measures for the Commission for Health Services. The findings are: 1. Review of Resident #2's current FL-2 dated 09/18/19 revealed: -Diagnoses included chronic kidney disease, hypertension, hyperlipidemia, cerebral infarction due to embolism, middle cerebral artery, and hypothyroidism. Review of Resident #2's Resident Register	D 234		

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D 234	Continued From page 14 revealed Resident #2 was admitted to the facility on 02/23/18. Review of Resident #2's resident record revealed there was no Tuberculosis (TB) skin test in the resident's record. Interview with the Administrator on 09/19/19 at 4:25pm revealed: -Resident #2 should have had his Tuberculosis (TB) skin test done on 07/15/19. -The Administrator scheduled a TB skin test on 07/15/19 for residents who did not have a TB skin test in their records. Interview with the Administrator on 09/20/19 at 10:07 revealed Resident #2 was not in the facillity 07/15/19 and had not received his TB skin test because he was at a medical appointment. Attempted telephone interview with Resident #2's family member on 09/19/19 at 4:02pm and 09/23/19 at 10:40am was unsuccessful. Interview with the Administrator on 09/24/19 at 3:32pm revealed: -TB skin testing for residents should be done upon admission into the facility. -She did an audit of resident's records in May 2019 and identified 19 residents who did not have a TB test in their records. -All residents who did not have a TB skin test were scheduled to have a test done on 07/15/19 and had their test read by a nurse from the contracted pharmacy on 07/18/19. -She attempted to reschedule Resident #2's TB skin test, but she was unable to get the serum due to the shortage. -She was concerned with residents who did not have TB skin testing done that were in the facility.	D 234		

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D 234	Continued From page 15 -She was concerned for herself, other residents, and her staff were at risk for getting TB. Interview with the Management Liaison on 09/25/19 at 5:52pm revealed that it was the responsibility of the office manager, but primarily the Administrator to ensure each resident had their TB skin test completed upon admission. Refer to interview with the Special Care Unit (SCU) Director on 09/19/19 at 12:14pm. Refer to interview with the Administrator on 09/24/19 at 2:36pm. 2. Review of Resident #3's current FL-2 dated 03/18/19 revealed: -Her diagnoses included vascular dementia, aphasia, cerebral vascular accident, hypertension, hyperlipidemia, major depressive disorder. -Her recommended level of care was secured. -she was intermittently disoriented. -She was ambulatory and was a wanderer. -She needed assistance with bathing. -She had an allergy to purified protein derivative (PPD- used to test for tuberculosis (TB) exposure). Review of Resident #3's Resident Register revealed she was admitted to the facility on 11/06/15. Review of Resident #3's record revealed no documentation of a TB skin test, a chest x-ray or an interferon gamma release assay (IGRA) blood test that screens for exposure to TB. Interview with the Secure Care Unit Director (SCUD) on 09/18/19 at 5:07 p.m. revealed:	D 234		

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D 234	Continued From page 16 -There were 18 residents who received a TB skin test which was administered on 07/15/19 by the facility's corporation Registered Nurse. -Resident #3 was one of the 18 who received a TB skin test on that date. -These 18 residents' TB skin test should have been read on 07/18/19 by the facility's pharmacy Registered Nurse. -The read TB skin test should have been filed in the residents' record. -He would locate these TB skin test which were administered on 07/15/19 and read on 07/18/19. Review of the documentation of the TB skin tests which were administered on 07/15/19 provided by the SCUD 09/20/19 revealed: -There was documentation of a TB skin test administered to Resident #3. -There was no documentation of read results. Interview with the SCUD on 09/20/19 at 12:12 p.m. revealed: -The TB skin test that was administered to Resident #3 on 07/15/19 was read on 07/18/19. -He was not aware that Resident #3 had an allergy to the PPD serum. No further documentation of TB skin test was provided to the survey team by 09/26/19, the date team exited from the facility. Interview with the Administrator on 09/24/19 at 2:56 p.m. revealed: -The first TB skin test was administered and read at admission to the facility. -Then the second TB skin test was administered and read 2 weeks after admission. -There were 19 residents, including Resident #3, who were identified during the facility's resident record audit in May 2019.	D 234		

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-There were TB skin test placed for 18 residents on 07/15/19 and were read on 07/18/19.
-The TB test forms were placed in Administrator's box then given to the medication aides in the secure care unit (SCU) and the assisted living (AL) unit to be filed in each of the 18 residents' records.

Refer to interview with the Special Care Unit (SCU) Director on 09/19/19 at 12:14pm.

Refer to interview with the Administrator on 09/24/19 at 2:36pm.

3. Review of Resident #5's current FL-2 dated 03/18/19 revealed diagnoses included dementia, benign prostate hypertrophy, hypertension and Raynaud's syndrome.

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 05/20/16.

Review of tuberculosis (TB) testing results for Resident #5 revealed there was one negative TB skin test result dated 12/09/16; there was no second TB skin test.

Telephone interview with Resident #5's primary care provider (PCP) on 09/25/19 at 9:19am revealed:
-She did not know Resident #5 needed a second TB skin testing.
-Resident #5 lived in an enclosed environment with other residents so if he did have TB disease, he would be exposing the entire facility.

Interview with the Special Care Unit (SCU) Director on 09/20/19 at 12:14pm revealed:
-He was unable to find a second TB skin test

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result for Resident #5.
-There was a Marketing Director until three months ago (June 2019), who was responsible for making sure initial TB skin tests were done prior to admission.
-He and/or the Administrator were responsible for reviewing resident records and assuring any needed second TB skin tests were done.
-He had a tracking tool/spreadsheet he used to keep track of which residents needed TB skin tests.
-Resident #5 was on the list to have a TB skin test; he did not know the status of TB skin testing for Resident #5.

Interview with the Administrator on 09/24/19 at 2:36pm revealed Resident #5 was not identified and on the list from June 2019 of residents who needed to have TB skin testing completed.

Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.

Attempted telephone interview with Resident #5's Power of Attorney on 09/19/19 at 10:55am was unsuccessful.

Refer to interview with the Special Care Unit (SCU) Director on 09/19/19 at 12:14pm.

Refer to interview with the Administrator on 09/24/19 at 2:36pm.

4. Review of Resident #14's current FL-2 dated 01/18/19 revealed diagnoses included dementia, atrial fibrillation, anemia, type II diabetes mellitus, gout, long term anticoagulant use and pedal edema.

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Review of Resident #14's Resident Register revealed Resident #14 was admitted to the facility on 09/25/17.

Review of tuberculosis (TB) testing results for Resident #5 revealed there was one negative TB skin test result dated 09/22/17; there was no second TB skin test.

Interview with Resident #14's family member on 09/23/19 at 4:30pm revealed:
-Resident #14 moved into the facility on 09/25/17.
-Resident #14 did not have a second tuberculosis (TB) skin test after admission to the facility.
-Resident #14 was identified by staff as needing a second TB skin test in June 2019 but did not have repeat TB skin testing done.

Telephone interview with Resident #14's primary care provider (PCP) on 09/26/19 at 8:27am revealed she had not been contacted by staff regarding TB testing for Resident #14; TB testing could be done at the PCP's office.

Telephone interview with the Administrator on 09/26/19 at 11:27am revealed:
-Resident #14 was not added to the June 2019 list of residents in need of TB testing because his family member did not want any other PCP seeing him other than his own PCP.
-Resident #14's family member knew she needed to take the resident to get TB testing done.
-Resident #14's family member did not want staff contacting the resident's PCP; when she tried to contact the PCP, she was not able to get through to the PCP or their nurse.
-She did not try calling the PCP telephone number listed on the front inside cover of Resident #14's record; she used the general number for the local hospital.

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D 234	Continued From page 20 Second interview with Resident #14's family member on 09/26/19 at 4:15pm revealed: -No one at the facility had mentioned her getting the TB testing done for Resident #14. -No one at the facility ever told her it was her responsibility to get Resident #14 tested for TB. Refer to interview with the Special Care Unit (SCU) Director on 09/19/19 at 12:14pm. Refer to interview with the Administrator on 09/24/19 at 2:36pm. _____ Interview with the Special Care Unit (SCU) Director on 09/19/19 at 12:14pm revealed: -A lot of the residents who needed TB skin tests were admitted before he and the Administrator became management at the facility. -The Administrator was responsible for identifying residents in need of TB skin testing in June 2019 and coordinating testing. -A Registered Nurse from the corporate office was brought in to place TB skin tests for a list of residents on 07/15/19. -The TB skin test results were read by the pharmacy nurse. -There was a risk of having a resident with TB in the facility if testing was not completed. Interview with the Administrator on 09/24/19 at 2:36pm revealed: -The first TB skin test was supposed to be done prior admission to the facility and the second step two weeks later. -The Resident Care Coordinator (RCC) and/or SCU Director were responsible for making sure each resident had a two-step TB skin test completed. -She had completed an audit of resident records	D 234		

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D 234	Continued From page 21 and identified 19 residents that needed TB skin testing completed. -There were 18 residents who had TB skin tests placed on 07/15/19 that were read by the pharmacy nurse. -There was not a RCC to assist with care coordination and follow up for things like TB testing. -TB testing was done because TB was a communicable disease, if a resident had TB disease they could be contagious to all of the residents. The facility failed to assure four residents were tested for tuberculosis disease as indicated. The failure of the facility to assure residents were tested for tuberculosis disease placed residents at risk of TB infection and was detrimental to the health and welfare of residents which constitutes a Type B Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.	D 269		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure the personal care needs were provided according to the residents' needs and care plan for 2 of 7 sampled residents including toileting, repositioning every 1 to 2 hours, incontinence care (Resident #17) and repositioning (Resident #11).

The findings are:

1. Review of Resident #11's current FL-2 dated 02/01/19 revealed:
-Her diagnoses included Alzheimer's dementia, constipation and osteoporosis.
-Her recommended level of care was secured.
-She was constantly disoriented.
-She was non-ambulatory.
-She was incontinent of bladder and bowel.
-She required total care.
-An order for Santyl ointment (used to help the healing of skin ulcers) 250/ gram, apply to right lateral ankle daily.
-An order for heel and ankle protectors to wear when in bed.

Review of Resident #11's Resident Register revealed:
-She was admitted to the facility on 11/29/16.
-She had significant memory loss and must be

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directed.
-She required assistance with getting in and out of bed, toileting and bathing.

Review of Resident #11's care plan signed by primary care physician (PCP) 02/01/19 revealed:
-That Resident #11 was totally dependent with her care.
-She required skin care needs of Santyl ointment to her right lateral ankle.

Review of Resident #11's Home Health Nurse (HHN) Nurses Notes revealed:
-On 01/09/19 there was documentation skilled nursing was completed and wound healed with current order for border foam daily.
-On 01/14/19 there was documentation skilled nursing was completed with assisted living facility (ALF) staff changing dressing daily and all skin was intact.
-On 01/16/19 there was documentation skilled nursing was completed and at arrival Resident #11 was found laying in bed with right ankle flat to mattress.
-The ALF staff was educated on the importance of pressure relief.
-Resident #11 had feet protectors that should have been worn while resident was in the bed, but were in the chair beside the resident's bed.
-On 02/12/19 there was documentation skilled nursing was completed and there was no open wound on resident's right ankle.
-On 07/10/19 there was documentation Resident #11 had a pressure area on her left hip and staff was advised to turn resident every hour or as needed.
-On 07/17/19 there was documentation Resident #11 had open wound on right ankle with discoloration on surrounding ankle.
-The MA cleaned and wraped area and placed

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foam bootie on resident's foot for extra cushion.
-MA would continue to monitor open wound on right ankle area.
-On 07/18/19 there was documentation Resident #11 right ankle was cleaned and dressed and would continue to monitor.
-On 07/18/19 on the 3:00 p.m. to 11;00 p.m. shift there was documentation Resident #11 had pressure sore on right ankle wrapped and cleaned daily with bootie applied.
-Staff had been advised to reposition Resident #11 each hour.
-Pressure sore on Resident #11's left ankle had a bright red color on 07/17/19, but on 07/18/19 redness on left ankle had returned to normal color.
-Resident #11 wil be closely monitored and referred to home health.
-Resident #11's PCP was made aware of pressure sore.
-On 07/19/19 on the 11:00 p.m. to 7:00 a.m. shift there was documentation that Resident #11's ankle with pressure sore was wrapped and cleaned with booties applied the entire shift.
-Resident #11 was repositioned each hour and will continue to monitor.
-On 07/20/19 there was documentation Resident #11's pressure sore on her right ankle was cleaned with normal saline, triple antibiotic ointment was applied and right ankle was rewrapped.
-On 07/21/19 and 07/22/19 there was documentation Resident #11's right ankle was cleaned and dressed, will continue to monitor.
On 07/22/19 there was documentation Resident #11's right ankle was cleaned and wrapped.
On 07/23/19 on the 3:00 p.m to 11:00 p.m shift there were documentations that Resident #11's wound on right ankle was cleaned and wrapped.
-Resident #11 needed to be turned every hour to

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prevent any pressure sores.
On 07/24/19 there was documentation Resident #11's right ankle was cleaned and wrapped.
-The HHN came to facility to evaluate and admitted Resident #11 for treatment.
-On 07/24/19 on the 3:00 p.m to 11:00 p.m shift there was documentation that Resident #11 was seen by her PCP .
-On 07/29/19 there was documentation HHN came to facility to treat Resident #11's right ankle.
-On 08/02/19 there was documentation HHN came to facility to clean and treat Resident #11's right ankle.
-On 08/07/19 there was documentation HHN came to facility to clean and treat Resident #11's right ankle.
-The HHN stated they were going to change her frequency of visits during the week for more treatments.

Interviews with staff revealed:
- Resident #11 was no longer at the facility.
-Resident #11 was discharged on 08/08/19 to a higer level of care because of the stage III pressure ulcer on her right ankle.

Interview with the HHN on 09/20/19 at 12:12 p.m. revealed:
-HHN visited Resident #11 at the facility on 07/24/19, evaluated and admitted her for treatment to a pressure ulcer on her right lateral ankle.
-HHN stated that Resident #11 right ankle pressure ulcer was a stage II, boderline stage III when it was evaluated on 07/24/19.
-He had maybe 4 visits with Resident #11 prior to her discharge from the facility to a higher level of care.

Interview with a personal care aide (PCA) on

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D 269	Continued From page 26 09/25/19 at 9:20 a.m. revealed: -Resident #11 required total care. -Resident #11 had to be turned every 2 hours and positioned with pillows between her legs. -When she took care of Resident #11, she was turned every 1 to 2 hours. Confidential interview with staff revealed: -The staff was not sure that 3rd shift was turning Resident #11 like they should because on 1st shift in the morning her right ankle bone would be very red. -When the wound was reported the wound on her ankle was a stage II. -Resident #11 required two persons to turn and reposition her. -The staff was verbally told by the Special Care Unit Director (SCU) Director and the Administrator that Resident #11 was to be turned every 2 hours. -The Administrator (who was a Licensed Practical Nurse) went over how to turn and reposition Resident #11 in our staff meetings. Interview with another PCA on 09/25/19 at 5:12 p.m. revealed she could tell when Resident #11 was not turned because her hip would look red. Interview with Resident #11's primary care physician (PCP) on 09/26/19 at 12:38 p.m. revealed: -She was notified of a new pressure ulcer mid-July 2019. -She prescribed heel and ankle protectors to help prevent pressure ulcers on Resident #11's feet and ankles. -She gave a telephone order for home health to come to assess and treat prior to her visit. -She visited Resident #11 on 07/24/19 and found she had a stage III pressure ulcer on her right	D 269		

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D 269	Continued From page 27 lateral ankle. -The stage III pressure ulcer was red with cloudy yellow pus drainage. -There was a stage I pressure ulcer on her left lateral ankle. -She asked staff where the heel and ankle protectors because Resident #11 should be wearing them while in bed. -The staff did not know where the heel and ankle protectors were. -The staff did not know how long they have been missing. -She spoke with the SCU Director who notified her about Resident #11's pressure ulcers and the Administrator on July 24, 2019 about her concerns with Resident #11's personal care. -She was upset the resident had developed new pressure ulcers and she was not notified until she had one that was a stage III. -She was also concerned that the facility staff were not aware that Resident #11 was not wearing her protectors and that staff could not find the protectors. -She was also concerned that Resident #11 had not been turned as frequently as she needed to be turned. -Resident #11 would not have developed a stage III pressure ulcer on her right ankle if she had been repositioned. Interview with the (SCU) Director on 09/26/19 at 9:57 a.m. revealed: -Resident #11 was to be changed every 2 hours and repositioned every 2 hours. -The procedure for residents who are total care was that they are to be changed and turned every two hours. -The (SCU) Director could not say for sure if Resident #11 was turned every 2 hours.	D 269		

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D 269	Continued From page 28 2. Review of Resident #17's current FL-2 dated 04/17/19 revealed: -Diagnoses included dementia, hypothyroidism, vitamin B12 deficiency and osteoarthritis of the knee. -Resident #17 was constantly disoriented, semi-ambulatory and incontinent of bowel and bladder. -Resident #17 needed assistance with bathing and dressing. Review of Resident #17's Resident Register revealed the resident was admitted to the facility on 02/25/19. Review of Resident #17's current care plan dated 06/06/19 revealed: -Resident #17 was ambulatory and always disoriented. -Resident #17 had daily bowel and bladder incontinence. Resident #17 was totally dependent on staff for bathing, oral care, incontinence care and dressing. Observations on 09/23/19 from 3:24pm until 3:32pm revealed: -There was a strong odor of urine on the special care unit (SCU) from the entrance door, in the main hallway and in the common area. -Resident #17 was sitting in the common area and stood to reveal the seat of her pants down to her thighs was wet and smelled of urine. -Upon prompting by the surveyor, staff assisted Resident #17 to her room for incontinence care. -Resident #17's incontinence brief was saturated with urine and feces with a strong odor. -The staff cleaned the resident's genitals and buttocks.	D 269		

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D 269	Continued From page 29 -There was deep redness and dried feces on Resident #17's groin and upper thighs. -Upon prompting by the surveyor, the staff cleaned the areas of redness and dried feces. Interview with the personal care aide (PCA) on 09/23/19 at 3:32pm revealed: -She did not know when the last time Resident #17 had been changed. -She was not assigned to work with Resident #17 first shift that day (09/23/19) and could not remember who was. -Resident #17 urinated frequently. Interview with a second PCA on 09/23/19 at 4:07pm revealed: -Residents were frequently not clean when the shift started. -Residents were frequently in bed with the bed soaked and the residents' briefs soaked when first shift started (7:00am). -PCAs reported residents being soaked at change of shift to the medication aides (MAs)/Supervisor all the time. -She tried to change residents' incontinence brief three to four times every shift. -There were four residents on the SCU that urinated frequently, Resident #17 did not urinate frequently. Interview with a third PCA on 09/23/19 at 4:20pm revealed Resident #17 did not urinate frequently. Observations of the PCA providing Resident #17 with personal care on 09/24/19 at 6:13pm revealed: -Resident #17 had a dried stain on the seat of her pants with wet areas at her upper thighs on both sides. -Resident #17's incontinence brief was saturated	D 269		

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with urine and feces with a strong odor.
-Resident #17's groin and upper thighs remained red.

Second interview with the second PCA on 09/24/19 at 6:13pm revealed:
-They had been short staffed at the beginning of first shift on 09/24/19.
-When there were only two PCAs working they were always running from one resident to the next.
-Each PCA would have to take turns assisting residents with toileting, incontinence care and bathing.
-One PCA had to be in the common area to watch residents because the MAs had to be able to pass medications.
-She was just getting to change Resident #17's incontinence brief for second shift.

Telephone interview with a MA/Supervisor on 09/26/19 at 9:15am revealed:
-She was not on the floor when PCAs were assisting residents with bathing and toileting.
-She "guessed in a sense" she was responsible for supervising the PCAs.
-She knew residents were getting bathed and assisted with toileting and incontinence care because the PCAs completed a skin assessment sheet for each resident bathed on each shift and turned the sheet into the MA/Supervisor on duty.
-There was not a toileting schedule, it was "common sense to assist with incontinence care and toileting every two hours."

Telephone interview with Resident #17's Power of Attorney (POA) on 09/26/19 at 1:57pm revealed:
-Staff did as little as possible to get by; staff did not change residents' incontinence briefs.
-She visited two to three times every week and

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picked up Resident #17's laundry to clean; every pair of pants was wet with urine every time.
-The closet would smell of urine from the dirty laundry.
-The Administrator said she would do something about it but never did.

Telephone interview with Resident #17's primary care provider (PCP) on 09/25/19 at 9:19am revealed:
-Prolonged intervals between incontinence care for Resident #17 could contribute to high risk for skin breakdown and urinary tract infections (UTIs).
-She did not know of any recent UTI's or skin breakdown for Resident #17.
-Sometimes at visits to the facility she would have concerns about residents' appearance and smell; she could not recall if she had concerns specifically about Resident #17.
-When she noticed a resident needed personal care assistance, she brought it to the MA on duty who would find someone to clean the resident.

Telephone interview with the SCU Director on 09/26/19 at 9:58am revealed:
-Staff were expected to provide toileting and incontinence care every two hours for residents; that was the facility policy.
-Sometimes he had to scramble enough staff together to provide care according to the facility's policy due to call outs.

Interview with the Administrator on 09/24/19 at 2:36pm revealed:
-There was a staffing problem at the facility; there was not enough staff and staff frequently worked 16 or more hours consecutively.
-Staff were not able to work these hours consistently and be able to provide adequate care

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D 269	Continued From page 32 including every two hour toileting and repositioning and bathing three times a week. -If there were more staff they could provide more frequent incontinence care and repositioning and there would be no skin breakdown. Based on observations, interviews and record reviews, it was determined Resident #17 was not interviewable. The facility failed to provide personal care assistance according to the care plan and needs of two sampled residents. The facility's failure to provide toileting, incontinence care and repositioning assistance resulted in a stage III ulcer on Resident #11's ankles and red and raw areas on Resident #17's groin and inner thighs. The facility's failure to provide personal care assistance to the residents was detrimental to the health of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#2 and #3) according to the needs of the residents who demonstrated exit seeking behavior (#3), left the Special Care Unit (SCU) without knowledge of the staff and was found one half mile from the facility in need of emergency medical attention for dehydration and (#2) who exhibited aggressive behaviors toward other residents.

The findings are:

1. Review of Resident #3's current FL-2 dated 03/18/19 revealed:
-Diagnoses included vascular dementia, aphasia, cerebral vascular accident, hypertension, hyperlipidemia, major depressive disorder.
-Her recommended level of care was secured.
-She was intermittently disoriented.
-She was ambulatory and had wandering behaviors.

Interview with the Administrator on 09/18/19 at 9:38 a.m. revealed:
-Resident #3 had been exit seeking for awhile before she eloped.
-She tried to push on the doors to get out.
-The staff did not know how Resident #3 got out.
-The staff was not aware that Resident #3 was

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missing prior to the call from the emergency management service (EMS).
-Resident #3 continued to exit seek, she even attempted to exit out one of the doors on August 12, 2019 while the county and county supervisor were in the building.

Interview with a personal care aide (PCA) on 09/18/19 at 2:31 p.m. revealed:
-Resident #3 liked walking up and down the hallways and pushed on the doors.
-The PCA had seen Resident #3 pressing the numbers on the key pads.

Confidential interview with a staff member revealed:
-Resident #3 always tried to get out the exit doors.
-Her room was at the end of the hall right next to one of the exit doors.
-Saw Resident #3 pressing numbers on the key pad trying to figure out the code at least twice before she eloped.

Review of the facility's incident accident report for Resident #3 dated 07/31/19 revealed:
-Resident #3 eloped at 1:11 p.m.
-She was placed on 1 on 1 supervision for 48 hours.

Review of the emergency management service (EMS) report for Resident #3 dated 07/31/19 revealed:
-They had received a call concerning a female possible lying next to the roadway.
-EMS arrived on the scene where Resident #3 was located sitting on the ground.
-They assessed Resident #3 and found that her blood pressure (bp) and pulse were elevated, bp was 170/90 (normal bp range for adult female is

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120/80 - 140/90), pulse was 150 (normal range for adults is 60 to 100).
-Her skin was dry but had some signs of possible dehydration with tenting of skin.
-IV fluids were started.
-She was transported to the emergency room (ER) via stretcher by EMS.

Review of Resident #3's ER records dated 07/31/19 revealed:
-The resident presented at the ER with confusion and disorientation.
-Resident #3 had wandered out of the facility's secure care unit and was found sitting under a tree.
-ER record noted Resident #3 was not oriented to person, place, time and situation.

Observation of the roadway on 09/20/19 at 2:30 p.m. where Resident #3 walked and was found by EMS revealed:
-The road was a primary four lane highway.
-It was a busy highway with a speed limit of 45 with many large tractor trailer trucks traveling on it.
-There was a large shopping center on the roadway directly across the street from the facility where traffic was constantly going in and out.
-There were many businesses along the side of the roadway with traffic constantly going in and out.

Interview with a personal care aide (PCA) on 09/18/19 at 2:31 p.m. revealed:
-EMS called the facility and sent a picture to the facility to identify her.
-Staff was not aware that Resident #3 was missing until they received the call from EMS.
-Resident #3 continued to exit seek even after she eloped by pushing on the exit doors and

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pressing the buttons on the key pads.
-There were no new interventions put in place when Resident #3 returned..

Interview with a medication aide (MA) on 09/18/19 at 4:00 p.m. revealed:
-The facility sent a MA to the scene which was a 5 minute drive.
-The MA arrived at the scene at 1:15 p.m. and observed Resident #3, who was flushed red in the face.

Interview with the Ombudsman on 09/23/19 at 4:20 p.m. revealed:
-On 08/02/19, she went into the SCU and asked a staff where Resident #3 was.
-The staff did not know.
-They observed Resident #3 come out of her room, pushed the exit door next to her room and went out the door.
-There was no staff supervising her 1 on 1.
-The exit door alarm did not sound.
-When she went and looked at the door, there was a butter knife wedged in the door's maglock security system.
-She notified the Secure Care Unit Director (SCUD) who said he would investigate the incident.

Interview with the SCU Director on 09/18/19 at 5:07 p.m. revealed:
-He was not in the building when the elopement incident occurred on 07/31/19.
-Resident #3 was placed on 1 on 1 supervision for the 3 weeks prior to her discharge.
-Extra staff was scheduled for 1 on 1 with Resident #3.
-He did not know how Resident #3 got out of the SCU two days later while she was on 1 to 1 supervision.

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D 270	Continued From page 37 -The extra staff was not listed on the schedule when they do 1 on 1 supervision with with residents. Interview with the SCU Director on 09/24/19 at 10:00am revealed he would look for any one on one checks for Resident #3 for the last 6 months. Review of the staff time punch record from 08/06/19 to 08/20/19 revealed. -There was no punch time by extra staff to cover 1 on 1 supervision of Resident #3. -Staff scheduled during the three shifts was minimal and at times short. -The shifts that the SCU Director and the Administrator worked as direct care staff was to cover holes in the schedule. Attempted telephone interview with Resident #3's family member on 09/23/19 at 5:15 p.m. and 5:22 p.m. were unsuccessful. Interview with Resident #3's primary care physician on 09/25/19 at 9:00 a.m. revealed: -She was notified that Resident #3 was found walking outside behind the facility's buildings on 07/31/19. -She was not aware that Resident #3 had left off the facility grounds. -She was familiar with the scene where Resident #3 was found. -She did not believe that Resident #3 would be able to walk that distance in 15 minutes due to her inability to walk without limping and dragging her right leg. Interview with the Administrator on 09/18/19 at 9:38 a.m. revealed: -She was not in the facility on 07/31/19 at the time Resident #3 eloped.	D 270		

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D 270	Continued From page 38 -Resident #3 had been exit seeking for a while before her elopement happened. -Resident #3 was kept on 1 on 1 supervision for 3 weeks after her elopement. -There were always 3 to 4 staff scheduled in the SCU. -She was not aware that Resident #3 had eloped from facility building at least two other times prior to her elopement. -Resident #3 continued to make attempts to get out of the SCU and was successful on 08/02/19. -The facility made the decision to discharge Resident #3 to a facility that was only a secure care unit facility that had a two step system, key pad and lever on door that had to be deactivated in order for anyone to go through it. 2. Review of Resident #2's current FL-2 dated 09/18/19 revealed: -Diagnoses included chronic kidney disease, hypertension, hyperlipidemia, cerebral infarction due to embolism, middle cerebral artery, and hypothyroidism. -The resident was constantly disoriented. -The resident was ambulatory. -The recommended level of care was documented as domiciliary home and "other"/special care unit (SCU). Review of Resident #2's Resident Register revealed: -Resident #2 was admitted to the facility on 02/23/18. -Resident #2 was forgetful and required assistance with orientation to time and place. -Resident #2 required assistance with bathing, toileting, dressing, and grooming. Review of Resident #2's Resident Profile/Care plan dated 04/9/19 revealed:	D 270		

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D 270	Continued From page 39 -Resident #2 wanders and required to reside in the special care unit (SCU). -The resident was ambulatory without an assistive device. -The resident was fully dependent on staff for bathing, toileting, and dressing. -The Resident Profile/Care plan was signed by Resident #2's primary care provider (PCP) and dated 04/10/19. A. Confidential interview with a staff member revealed: -They saw Resident #2 be aggressive towards other residents but did not know specific dates. -The resident was observed pushing another resident out of a chair in the dining room, the date was not known. -Both residents started fighting after Resident #2 knocked the resident out of the chair. -The MA was notified of the accident/incident. -They were unsure if an accident/incident report was completed for the incident in the dining room. -The medication aide on duty at the time of the accident gave the resident his as needed (PRN) Ativan, the incident was reported to Resident #2's family member, and the mental health provider was notified. -Protocol for an aggressive accident/incident was to deescalate the situation, and redirect Resident #2. Interview with a PCA on 09/23/19 at 3:26pm revealed: -She saw Resident #2 be aggressive with other residents, she was not sure of the dates of the incidents. -Resident #2 kicked another resident a few days ago because the other resident rolled over his foot. -Last week Resident #2 hit another resident in the	D 270		

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common sitting area in the middle of the SCU and left a bruise on her arm.
-Resident #2 had a doctor's appointment prior to hitting the resident and when he came back, he hit the other resident.
-An accident/incident report should have been done but she was unsure if it had been completed.

Review of Care Note for Resident #2 dated 3/21/19 at 5:30pm revealed:
-Resident #2 walked into another resident's room, the resident in the room advised Resident #2 to get out and pushed him.
-Resident #2 slapped the other resident in face and caused 2 scratches on the resident's face.
-The mental health provider was notified, the primary care physician was notified, the resident's family was notified, and the administrator was notified.

Review of Care note for Resident #2 dated 3/21/19 at 5:35pm revealed:
-Resident #2 kicked another resident's wheelchair because the wheelchair ran over his foot.
-Resident #2 was isolated from the other residents, the patient was given his as needed medication, placed on 15 minute watch for 72 hours, primary care physician was notified, mental health provider was notified, the residents family, and the admin.
-There was no documentation that the resident was placed on one on one checks.

Review of Care note for Resident #2 dated 4/22/19 at 5:00pm revealed:
-Resident #2 was found on top of another resident punching her, the resident care coordinator and the activities director jumped in to stop the fight.

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-Resident #2 started punching the activities director in her ribcage.
-Resident #2's primary care physician and family member were called.
-Resident #2 was given a dose of medication to help him relax.
-Resident #2 was placed on 15 minute checks and separated from the other resident.

Review of Resident #2's record revealed there was no documentation Resident #2 was placed on increased supervision on 04/22/19.

Review of Incident Accident report for Resident #2 on 04/22/19 at 5:09pm revealed:
-Resident #2 was found in a resident's room with a head injury.
-The primary care physician was notified by fax of the incident.
-The resident was placed on 15 minute checks, he received medication to help stop the patient from being combative, both residents were separated for the rest of the night.

Review of Resident #2 record revealed there was no documentation that he was placed on 15 minute checks on 04/22/2019.

Interview with the Activity Director on 09/24/19 at 10:30 am revealed management at the facility has not done anything to protect other residents from Resident #2.

Review of Incident Accident report for Resident #2 on 05/08/19 at 11:05am revealed:
-Resident #2 was found in the dining room in an altercation with 2 other residents.
-The type of injury was documented as "none" present.
-The primary care physician was notified, and it

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was documented to keep her updated.
-The residents involved in the accident were separated and redirected to other areas.

Review of Resident #2 record revealed there was no documentation he was placed on one on one or increased supervision on 05/08/19.

Review of Care notes for Resident #2 dated 07/18/19 revealed:
-The resident was accused of kicking another resident out of her wheelchair.
-The other resident was taken to the emergency room as a result of the incident.
-The resident was placed on 15 minute checks due to behavioral issues.

Review of Resident #2 record revealed there was no documentation that he was placed on 15 minute checks on 07/18/19.

Review of the Incident Accident report for Resident #2 on 07/18/19 at 10:30am:
-Resident #2 had an injury to his right leg.
-This incident occurred in the hallway, it did not specify if the incident was witnessed.
-The primary care physician was notified, and the resident was placed on a 15 minute watch.
-Both residents were separated and taken to special areas, the other resident was placed on 15 minute checks.

Review of Resident #2 record revealed there was no documentation that he was placed on 15 minute checks.

Attempted telephone interview with Resident #2's family member on 09/23/19 at 3:49pm was unsuccessful.

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D 270	Continued From page 43 Telephone interview with a former PCA on 09/25/19 at 9:30am revealed: -She witnessed Resident #2 push a resident out of chair which resulted in the other resident going to the emergency room, she did not know the date. -Neither resident was placed on one on one checks, she was not sure why. -She witnessed Resident #2 kick another resident out of her wheelchair, the other resident was fine and did not require medical intervention, she did not know the date. -Neither resident was placed on one on one checks, she did not know why. -She witnessed Resident #2 get into a fight with another resident on seating in the dining hall, she did not remember the date. -The SCUD and the Administrator were there to help break up the altercation. -Both Resident #2 and the other resident were placed on 30 minute checks for 2-3 days, but both residents were seated beside each after the incident. -The management team was aware of all incidents/accidents involving Resident #2. -Resident #2 was aggressive the entire time she was employed at the facility, and nothing was done to protect the other residents. Confidential telephone interview with a former staff revealed: -When the staff worked at the facility, Resident #2 had aggressive behaviors which included hitting other residents. -Resident #2's aggressive behaviors could not be controlled when he became agitated. -Resident #2 wandered and went into other residents' rooms all the time. -Resident #2 was never placed on any one on one supervision when the former staff worked at	D 270		

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the facility.
-There was never any discussion of moving Resident #2 out of the facility because of his behaviors when the former staff worked at the facility.

Interview with Resident #2's PCP on 09/25/19 at 8:40am revealed:
-She had been seeing the resident since July 2017.
-She was aware of the behavioral occurrences that Resident #2 had at the facility.
-She did not know specific incidents or dates.
-The mental health provider manages Resident #2's psychiatric medications.

Interview with Resident #2's mental health provider on 09/25/19 at 4:10pm revealed:
-She had been working with the resident since 02/12/19.
-She last saw the resident at the beginning of September 2019.
-She was involved in managing his dementia and aggressive behavior.
-She was aware of the resident's incident/accidents involving other residents.
-She increased the residents' psychiatric medications to help with his aggression a couple months ago.
-Resident #2 had a girlfriend in the special care unit that was another resident, but she moved out in August 2019.
-She believed the 2 residents had a relationship and increased Resident #2's aggression.
-Resident #2's behaviors had decreased with the change in his medications and the resident's girlfriend leaving the facility.
-She was unaware of an incident the previous week involving Resident #2 kicking another resident.

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-Whenever there was an incident, she would receive a call or text from staff at the facility.
-She was going to increase one of the resident's medications to help manage his aggression better.

Review of Resident #2's behavioral health provider progress note dated 08/01/2019 revealed:
-She was treating the resident for advanced dementia with associated behaviors, dementia with behavioral disturbance, mood disorders, and anxiety.
-She increased Resident #2's antidepressant medication on 08/01/19 to two 100 mg tablets taken by mouth daily for mood stabilization.
-Resident #2 had been prescribed his antidepressant medication originally on 04/24/19.
-The antidepressant medication dose prescribed on 04/24/19 was 100 mg tablet, 1.5 tablet taken by mouth daily.
-The 04/24/19 order was discontinued on 08/01/19.
-In the treatment plan section, she encouraged Resident #2 mood and behaviors be monitored and be offered redirection as necessary.

B. Interview with a PCA on the SCU on 09/18/19 at 3:16pm revealed Resident #2 had exhibited exit seeking behavior since she worked at the facility for the past two years.

Observation of Resident #2 on 09/19/19 between 10:58am and 11:32am revealed:
-Resident #2 attempting to open side door of the north hall.
-Resident #2 was trying to lift the cover on the wall where the latch to open the door was located.
-Resident #2 was asked if he knew how to open

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the door and Resident #2 replied, "yeah, lift that thing up and it'll open."
-At 10:58am, a personal care aide (PCA) attempted to redirect Resident #2.
-At 11:21am, the activities director (AD) attempted to redirect Resident #2.
-At 11:32am, the activities director (AD) and the Administrator attempted to redirect Resident #2.

Observation of Resident #2 on 09/19/19 at 11:37am revealed the resident was at the exit door on the women's hall with the Activity Director pressing on the crash bar and trying to gain access to the emergency release lever for the door.

Observation of Resident #2 on 09/19/19 at 11:00am revealed he was in the activity director's office because he was agitated to deescalate his agitation.

Interview with a PCA on 09/19/19 at 11:05am revealed:
-Resident #2 saw a work truck outside of the facility and he had become agitated because he thought it was his work truck.
-Resident #2 wanted to go outside to the truck.
-Another PCA asked the workers to move the truck to help the resident calm down.

Interview with a MA on 09/19/19 at 11:10am revealed Resident #2 refused to take his as needed (PRN) medications that helped him calm down.

Interview with personal care aide (PCA) on 9/19/19 at 1:20pm revealed:
-The resident was trying to get out of the building, the staff member tried to stop him, and the resident pushed the staff member.

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D 270	Continued From page 47 -Resident #2 was agitated and tried to leave the facility. -When residents became aggressive staff reported it to the MA. Interview with the Administrator on 09/19/19 at 5:10pm revealed: -Resident #2 was a security guard, and he walked the halls of the SCU as if were still employed. -The activities director tried to stop a fight between Resident #2 and another resident. -This incident happened over six months ago. Interview with dietary wait staff on 09/19/19 at 10:09pm revealed: -He was called in to sit with Resident #2 only on 09/19/19 until 11:00pm because the resident had shown exit seeking and aggressive behaviors. -He was asked to come in by management staff of the facility. -He just watched Resident #2 he did not provide any direct resident care. -He monitored the resident just to watch his behaviors. -The resident did not show any exit seeking or aggressive behaviors during his shift. Confidential interview with a second staff member revealed: -Resident #2 was placed on one on one checks, for 72 hours starting on 09/19/19 due to aggressive behaviors. -Resident #2 was on one on one watch on 09/19/19, 09/20/19, and 09/21/19. -The one on one watch ended 09/21/19. -On 09/19/19 when Resident #2 showed aggressive behaviors towards other resident's the medication aide on duty contacted the resident's mental health provider. -If a resident on one on one's showed no	D 270		

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aggressive behavior in the 72 hours then the one on one's will end.
-When residents got into fights the policy is to separate the residents from each other, notify the doctor, notify the mental health provider, watch the residents for 72 hours.
-When Resident #2 did not have mutual feelings reciprocated by another resident, he became aggressive.

Interview with the Special Care Unit Director (SCUD) on 09/23/19 at 3:43pm revealed:
-Resident #2 had only been on one on one checks on 09/19/19.
-One on one checks for Resident #2 was discontinued because he didn't show any further aggressive behaviors.
-The definition of one on one was one watch staff member watching the one resident during a shift.
-He did not know why the confidential staff member said the resident was on one on one checks for three days.
-When a resident showed aggression, they were placed on one on one watch until they were no longer showed signs of aggression.
-On 09/19/19 the dietary wait staff was assigned to work one on one watch with Resident #2 for 7 or 8 hrs.

A request for the one on one check log for the past 6 months was made to the SCUD on 09/24/19 at 10:00am but was not provided.

Interview with the Chief Operating Officer (COO) on 09/24/19 at 11:47am revealed:
-When an accident/incident occurred the PCA was supposed to contact the supervisor.
-Then the supervisor was supposed to complete an accident/incident report.
-Then the supervisor was supposed to give the

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D 270	Continued From page 49 accident/incident report to the Administrator. -The Administrator was supposed to sign the accident/incident report and send the report to the Department of Social Service (DSS). -When a resident was found to need more supervision the supervision plan would be individualized to have met the residents needs at this time of the accident/incident. -If 15 minute checks were implemented it would have remained in effect for 72 hours. -After 72 hours she would determine if there was still a risk or need for the resident to have remained on 72 hour checks. -The facility kept a record of the one on one check logs, she would locate them and allow the surveyor to view the records. Interview with the Management Liaison on 09/25/19 at 2:55pm revealed: -The facility should have had a log of the one on one checks for residents. -She was supposed to provide the one on one log to the team. Attempted interview with Resident #2 on 09/17/19 at 12:15pm revealed the resident was not interviewable. Attempted telephone interview with Resident #2's family member on 09/19/19 at 4:02pm was unsuccessful. _____ The facility failed to assure supervision of Resident #2 and Resident #3 according to the needs of the residents on the residing on the special care unit (SCU). The facility's failure to supervise Resident #3 resulted in the resident being found half mile from the facility with elevated pulse and elevated BP with signs of dehydration and a second elopement two days	D 270		

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D 270	Continued From page 50 later. The facility's failure to supervise Resident #2, who was physically aggressive towards other residents resulted in another resident being sent out to the ER after being assaulted by Resident #2. These failures placed Resident #3, Resident #2, and other residents at substantial risk for serious harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/19/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 26, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to meet the health care needs for 2 of 7 residents (#9, #11) sampled by delaying notification to residents primary care providers	D 273		

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(PCP) related to a pressure ulcer on a resident's right hip (#9) and two pressure wounds on a resident's ankles (#11).

The findings are:

1. Review of Resident #9's current FL-2 dated 11/15/18 revealed:
-Diagnoses included Alzheimer's disease, osteoporosis and rheumatoid arthritis major.
-There was documentation the resident was intermittently disoriented.

Review of Resident #9's Assessment and Care Plan dated 11/15/18 revealed:
-The resident was always disoriented, had significant memory loss and had to be directed.
-The resident was totally dependent on staff for bowel and bladder needs and required extensive assistance from staff for bathing, dressing, ambulation and transferring needs.

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Review" dated 06/03/19 revealed:
-There was documentation of a rash with a circle drawn over the buttocks on a posterior full body diagram that indicated the location of the rash.
-The form was signed by a personal care aide (PCA).
-There was a signature of the supervisor dated 06/03/19.
-There was an entry "Forwarded to the RCC" (Resident Care Coordinator) with a checked entered as yes.
-In the RCC Assessment section, there was an entry "Small redness to area".
-There was an intervention section with an entry the resident had Zinc Oxide as a standing order. (Zinc Oxide is a topical medication used for skin

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irritations).
-The form was signed by the RCC in 06/11/19.

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Review" dated 06/20/19 revealed:
-There was documentation of abnormal skin with three circles drawn with two of the circles in the center of the buttocks and another circle over the lower portion of the back on a posterior full body diagram.
-The entry was signed by a PCA.
-There were no other signatures for the supervisor or RCC.

Review of Resident #9's Skin Monitoring Comprehensive CNA shower Review dated 06/26/19 revealed:
-There was documentation of redness with a large circle drawn over the entire buttocks on a posterior full body diagram and a large circle over the entire hip areas on an anterior full body diagram.
-There was no signature for the supervisor.
-There was entry "Forwarded to the RCC" with a checked entered as yes.
-In the RCC Assessment section, there was an entry "Areas very red".
-The form was signed by the RCC on 06/27/19.

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Review" dated 07/07/19 revealed:
-There was documentation of abnormal skin with one circle drawn over the outer right hip on an anterior full body diagram.
-The entry was signed by a PCA and the Supervisor.
-There was not a signature for the RCC.
-There was a second form with documentation of

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abnormal skin with one circle drawn over the outer right hip on an anterior full body diagram.
-The entry was signed by a PCA and the Supervisor.
-There was no a signature for the RCC.

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Reviews" dated 07/11/19 revealed:
-There was documentation of redness/raw with one circle drawn over the outer right hip on an anterior full body diagram and a large circle drawn over the entire buttocks on a posterior full body diagram.
-The entry was signed by a PCA and the supervisor.
-There was no signature for the RCC.

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Reviews" dated 07/13/19 revealed:
-There was documentation of abnormal skin with one circle drawn over the outer left hip on an anterior full body diagram.
-The entry was signed by a PCA and the supervisor.
-There was not a signature for the RCC.

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Reviews" dated 07/17/19 revealed:
-There was documentation of redness and an opened area with one circle drawn over the outer left hip on an anterior full body diagram and a large circle drawn over the entire buttocks a posterior full body diagram.
-The entry was signed by a PCA.
-There was no signature for the supervisor or RCC.

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Review of Resident #9's "Care Notes" revealed on 07/18/19, there was an entry the resident had breakdown on her upper right hip "small one".

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Reviews" dated 07/20/19 revealed:
-There was documentation of an opened area on the right hip and red buttocks area.
-There were no documented marked areas on the full body diagrams.
-The entry was signed by a PCA and the supervisor.
-There was not a signature for the RCC.

Review of Resident #9's "Skin Monitoring Comprehensive CNA Shower Reviews" dated 07/23/19 revealed:
-There was documentation of an opened area, redness on "bottom" with one circle drawn over the outer left hip on an anterior full body diagram and a circle drawn over the buttocks a posterior full body diagram.
-The entry was signed by a PCA.
-There was not a signature for the supervisor or RCC.

Review of Resident #9's "Care Notes" revealed on 07/23/19, there was an entry the resident had a pressure sore on her right hip, staff were advised to turn the resident every hour.

Review of a primary care provider's (PCP's) order for Resident #9 dated 07/24/19 revealed an order to consult Home Health, Registered Nurse (RN) for a stage 3 pressure ulcer on the right hip, sent to a named Home Health provider. (A stage 3 pressure ulcer has full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon or muscle would not be exposed. Slough

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may be present but would not obscure the depth of tissue loss). (Slough is a yellow/white material in the wound bed consisting of dead cells).

Review of Resident #9's "Care Notes" revealed:
-On 07/24/19, the residents pressure sore on the right hip was cleaned with saline and triple antibiotic ointment. A home health company was called and they were told a home health nurse would visit the resident the next day for the resident's assessment and admission.
-On 07/25/19, the home health provider came out to admit the residents and reported the pressure "spot" was a stage 2. (A stage 2 is used to describe a pressure ulcer that has partial thickness loss of the skin and presents as a shallow opened ulcer with a pink or red wound bed, without slough and could present as an intact or opened/ruptured blister).
-On 07/25/19, there was an entry with the time documented as "3-11", the home health provider came out and stated the pressure sore could be a stage 2.

Telephone interview with the Executive Director with Resident #9's Home Health company on 09/24/19 at 4:45pm revealed:
-A referral was received from Resident #9's PCP's office for a stage 3 pressure ulcer.
-Home Health was initiated on 07/25/19 for a Skilled Nursing three times a week.

Review of Resident #9's Skilled Nurse Home Health provider note dated 07/25/19 revealed:
-The residents start of care was 07/25/19.
-The resident's primary diagnosis was a pressure ulcer/injury of the right hip, unstageable and coded as symptoms poorly controlled.
-The right hip wound measured 2.0 cm in length, 1.0 cm in width and 0.01 cm in deep.

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D 273	Continued From page 56 -The depth description was documented as "Obscured by necrosis/Unstageable/Deep Tissue Injury (purple)". -The edges of the pressure ulcer/injury were distinct, outline clearly visible, attached and even with the wound base. There was no drainage. -The skin color surrounding the wound was pink or normal with no edema. -Under the integumentary status of the note the resident was assessed using a Braden Scale (a tool used for predicting pressure sore risks in home care). The resident scored a 13, meaning the resident was at moderate risk for developing pressure sores. -The resident's current number of unhealed pressure ulcers/injuries was documented as unstageable: slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar. (Eschar is dead tissue that sheds or falls off from healthy skin). -No wound care was provided on the visit due to no orders. -The resident had very limited mobility/endurance due to osteoarthritis. -In the skilled care section of the visit there was an entry the resident had a new development of an unstageable pressure wound on the right hip. Review of Resident #9's skilled nurse home health provider note dated 07/29/19 revealed: -The right hip wound measured 1.5 cm in length, 1.0 cm in width and 0.01 cm deep with a scant amount of drainage documented as a purulent type. (Purulent drainage is discharge from a wound that is often a sign of infection). -The wound was cleaned with a wound cleanser or normal saline and a gauze and dressed with silvercel and optifoam. (Silvercel is a non-adherent antimicrobial dressing and optifoam is an adhesive foam dressing).	D 273		

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D 273	Continued From page 57 Review of Resident #9's skilled nurse home health provider notes dated 07/31/19 and 08/02/19 revealed: -The right hip wound had loosely adherent yellow slough and a moderate amount of drainage documented as a purulent type. -The wound was cleaned with a wound cleanser or normal saline and a gauze and dressed with silvercel and opitfoam. Review of Resident #9's skilled nurse home health provider note dated 08/05/19 revealed: -The right hip wound measured 2 cm in length, 1.4 cm in width with loosely adherent yellow slough a moderate amount of drainage documented as a purulent type. -The wound was cleaned with a wound cleanser or normal saline and a gauze and dressed with silvercel and opitfoam. Review of Resident #9's skilled nurse home health provider note dated 08/08/19 revealed: -The right hip wound had loosely adherent yellow slough and a moderate amount of drainage documented as a purulent type. -The wound was cleaned with a wound cleanser or normal saline and a gauze and dressed with silvercel and opitfoam. Review of Resident #9's home health "Transfer to Inpatient Facility" form revealed the resident was discharged from home health services on 08/12/19 to a rehabilitation and nursing center. Telephone interview with the Resident #9's Home Health RN on 09/25/19 at 12:35pm revealed: -The resident's referral diagnosis was a stage 3 pressure ulcer but the she thought the pressure ulcer was unstageable with debris and build-up.	D 273		

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-On the resident's initial visit, there were no signs or symptoms of infection and no wound drainage.
-She made the first initial for the resident's start of care; subsequent visits were made by other nurses from the home health agency.
-Because the pressure ulcer was unstageable, the depth of the wound could not be seen.
-Staff claimed they had just noticed the pressure ulcer.
-Pressure ulcers developed from pressure from lying on an area or rubbing.
-A pressure ulcer would gradually progress if it was not treated.
-She did not think the resident could change positions independently and was dependent on staff for that.

Interview with a PCA on 09/25/19 at 9:33am revealed Resident #9 required total care.

Confidential interview with a staff revealed:
-Resident #9 was contracted, fragile and thin.
-Resident #9 had a pressure ulcer on her hip and had a cushion and a new wheelchair.
-When the pressure ulcer was brought to our attention, home health was consulted.
-The facility had standing orders for Resident #9 to clean skin areas with saline and dressing changes.
-The PCAs did not report Resident #9's hip ulcer until it was a stage 2.
-When staff started treating Resident #9's right hip it was already a stage 2

Interview with the Special Care Unit (SCU) Director on 09/26/19 at 9:58am revealed:
-The primary care provider (PCP) was notified sometime in July 2019 about Resident #9's hip wound.
-He would have to review the resident's record to

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give specific dates on when the right hip ulcer was found, reported and when Home Health was started.
-The facility's policy was to turn and position residents every two hours.
-He had created a spread sheet for staff to document when residents were repositioned.
-He would have to check Resident #9's record for documentation of every two hour repositioning.
-He could not say he witnessed staff reposition Resident #9 every two hours, but when he walked through the SCU he would check the resident's position to see if it had changed from the last time.

Interview with a medication aide (MA) on 09/25/19 at 9:25am revealed:
-A PCA had told her about Resident #9's wound.
-She saw a small red spot on Resident #9's hip.
-The day she wrote the note was the same day the PCA reported it and she looked at it.
-She documented the red spot and reported it to the first shift MA/Supervisor.

Telephone interview with Resident #9's PCP on 09/24/19 at 5:02pm revealed:
-When the PCP was notified the resident's right hip ulcer was "already" a stage 3.
-She typically saw the resident one time a month and did not look at every inch of the skin.
-Since an assisted living facility could not take care of a stage 3 wound, the resident was ordered home health for wound care until the resident was placed in a higher level care facility.
-Pressure would have caused Resident #9's ulcer.
-Resident #9 had dementia and was thin which compromised her ability to adjust her weight herself.
-There would have been signs of the pressure

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area on the resident's right hip before the ulcer reached a stage 3 such as a closed red area, then an opened area then progression to a layer of dermal tissue loss.
-It was hard to say how long it would take the resident's pressure ulcer to progress to a stage 3 due to factors such as the degree of pressure to the area and nutritional status.
-The staff at the facility had her cell number and could have made efforts to contact her to prevent the progression of the resident's ulcer.
-She would have expected staff to have contacted her prior to the resident's wound reaching a stage 3 pressure ulcer.
-The pressure ulcer placed the resident at risk for sepsis or organ failure.

Interview with the Administrator on 09/26/19 at 11:27am revealed:
-The wound on Resident #9's hip was reported to her; she did not know the exact date.
-She did not know the wound was a stage III pressure ulcer when it was first reported to the primary care provider.
-Staff were expected to report wounds to the medication aide (MA)/Supervisor on duty.
-She did not provide direct care to residents and did not see residents' skin.
-The SCU Director was expected to review residents' skin assessments.
-She was not usually aware of every skin concern; she would only find out if the wound was "really bad."

Telephone interview with Resident #9's family member on 09/23/19 at 10:30am revealed:
-Resident #9 passed away 3 weeks ago from pneumonia/sepsis.
-The resident suffered from severe arthritis and dementia and had limited mobility.

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D 273	Continued From page 61 -The resident had "sores" on her buttocks and hip. 2. Review of Resident #11's current FL-2 dated 02/01/19 revealed: -Resident #11's diagnoses included Alzheimer's dementia, constipation and osteoporosis. -Resident #11's recommended level of care was secured. -Resident #11 was constantly disoriented. -Resident #11 was non-ambulatory. -Resident #11 was incontinent of bladder and bowel. -Resident #11 required total care. -An order for heel and ankle protectors to wear when in bed. Review of Resident #11's Resident Register revealed she required assistance with getting in/out of bed, toileting and bathing. Review of Resident #11's care plan signed by primary care physician (PCP) 02/01/19 revealed: -That Resident #11 was totally dependent with her care. -She required skin care needs of Santyl ointment to her right lateral ankle. Interview with a personal care aide (PCA) on 09/25/19 at 5:12 p.m. revealed: -That PCAs were to do a skin assessment every time they perform resident care and to report any concerns to the MA. -When she noticed that Resident #11's left ankle had some redness and her right ankle had an open area she reported it to the MA. -She could not recall the exact date but it was in July 2019. Interview with a medication aide on 09/25/19 at	D 273		

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D 273	Continued From page 62 5:48 revealed: -Resident #11 was always to wear heel and ankle protectors especially while in bed. -She was made aware of Resident #11's pressure ulcers by a PCA. -She immediately went to looked at Resident #11's ankles and notified the Special Care Unit (SCU) Director and Resident #11's primary care physician (PCP). -When she was made aware of Resident #11's pressure ulcers, the pressure ulcer on her left ankle was very red but the pressure ulcer on her right ankle was already an open wound. Review of Resident #11's Home Health Nurse (HHN) Nurses Notes revealed: -There was documentation in 2018 of prior episodes of pressure ulcers to Resident #11's right ankle. -On 01/09/19 there was documentation skilled nursing was completed and wound healed with current order for border foam daily. -On 01/14/19 there was documentation skilled nursing was completed with assisted living facility (ALF) staff changing dressing daily and all skin was intact. -On 01/16/19 there was documentation skilled nursing was completed and that at arrival Resident #11 was found laying in bed with right ankle flat to mattress. -The ALF staff was educated on the importance of pressure relief. -Resident #11 had feet protectors that should have been worn while resident was in the bed, but were in the chair beside the resident's bed. -On 02/12/19 there was documentation skilled nursing was completed and there was no open wound on resident's right ankle. -On 07/10/19 there was documentation Resident #11 had a pressure area on her left hip and staff	D 273		

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D 273	Continued From page 63 was advised to turn resident every hour or as needed. -On 07/17/19 there was documentation Resident #11 had open wound on right ankle with discoloration on surrounding ankle. -The MA cleaned and wraped area and placed foam bootie on resident's foot for extra cushion. -MA would continue to monitor open wound on right ankle area. -On 07/18/19 there was documentation Resident #11 right ankle was cleaned and dressed and would continue to monitor. -On 07/18/19 on the 3:00 p.m. to 11;00 p.m. shift there was documentation that Resident #11 had pressure sore on right ankle wrapped and cleaned daily with bootie applied. -Staff had been advised to reposition Resident #11 each hour. -Pressure sore on Resident #11's left ankle had a bright red color on 07/17/19, but on 07/18/19 redness on left ankle had returned to normal color. -Resident #11 wil be closely monitored and referred to home health. -Resident #11's PCP was made aware of pressure sore. -On 07/19/19 on the 11:00 p.m. to 7:00 a.m. shift there was documentation that Resident #11's pressure sore was wrapped and cleaned with booties applied the entire shift. -Resident #11 was repositioned each hour and will continue to monitor. -On 07/20/19 there was documentation Resident #11's pressure sore on her right ankle was cleaned with normal saline, triple antibiotic ointment was applied and right ankle was rewrapped. -On 07/21/19 and 07/22/19 there was documentation Resident #11's right ankle was cleaned and dressed, will continue to monitor.	D 273		

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D 273	Continued From page 64 On 07/22/19 there were documentations that Resident #11's right ankle was cleaned and wrapped. On 07/23/19 on the 3:00 p.m to 11:00 p.m shift there were documentations that Resident #11's wound on right ankle was cleaned and wrapped. -Resident #11 needed to be turned every hour to prevent any pressure sores. On 07/24/19 there was documentation Resident #11's right ankle was cleaned and wrapped. -The HHN came to facility to evaluate and admitted Resident #11 for treatment. -On 07/24/19 on the 3:00 p.m to 11:00 p.m shift there was documentation that Resident #11 was seen by her PCP . -On 07/29/19 there was documentation HHN came to facility to treat Resident #11's right ankle. -On 08/02/19 there was documentation HHN came to facility to clean and treat Resident #11's right ankle. -On 08/07/19 there was documentation HHN came to ficility to clean and treat Resident #11's right ankle. -The HHN stated that they were going to change her frequency of visits during the week for more treatments. Interview with the HHN on 09/20/19 at 12:12 p.m. revealed: -HHN visited Resident #11 at the facility on 07/24/19, evaluated and admitted her for treatment to a pressure ulcer on her right lateral ankle. -HHN stated that Resident #11 right ankle pressure ulcer was a stage II, boderline stage III when it was evaluated on 07/24/19. -He had maybe 4 visits with Resident #11 prior to her discharge from the facility to a higher level of care.	D 273		

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D 273	Continued From page 65 Interview with Resident #11's primary care physician (PCP) on 09/26/19 at 12:38 p.m. revealed: -She was notified of a new pressure ulcer mid-July 2019. -She prescribed heel and ankle protectors to help prevent pressure ulcers on Resident #11's feet and ankles. -She gave a telephone order for home health to come to assess and treat prior to her visit. -She visited Resident #11 on 07/24/19 and found she had a stage III pressure ulcer on her right lateral ankle. -The stage III pressure ulcer was red with cloudy yellow pus drainage. -There was a stage I pressure ulcer on her left lateral ankle. -She asked staff where the heel and ankle protectors because Resident #11 should be wearing them while in bed. -The staff did not know where the heel and ankle protectors were. -The staff did not know how long they have been missing. -She spoke with the SCU Director who notified her about Resident #11's pressure ulcers and the Administrator on July 24, 2019 about her concerns with Resident #11's personal care. -She was upset the resident had developed new pressure ulcers and she was not notified until she had one that was a stage III. -She was concerned that the facility staff were not aware that Resident #11 was not wearing her protectors and that staff could not find the protectors. -She was also concerned that Resident #11 had not been turned as frequently as she needed to be turned. Interview with the SCU Director on 09/26/19 at	D 273		

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D 273	Continued From page 66 9:57 a.m. revealed: -He was made aware of Resident #11's pressure ulcers in July 2019 by the medication aide (MA). -Resident #11 required to be provided incontinence care every 2 hours and repositioned every 2 hours. -Resident #11's PCP was notified of resident's pressure sores on her ankles in July 2019, he was not sure of the date. The facility failed to assure referral and follow up as evidenced by delaying notification to Resident #9's primary care provider (PCP) concerning a right hip pressure ulcer that progressed from a "very red area", open area to a Stage 3 pressure ulcer in a one month period before the resident's PCP was notified. Resident #9 required dressing changes from a home health nurse and a discharge from the facility by the PCP to a higher level of care for management of the wound. The delay of notification to Resident #9's PCP placed the resident at risk for sepsis and organ failure; #11 with a history of pressure ulcers to her right and left ankles developed a Stage III pressure ulcer. The facility's failure resulted in Resident #9 and Resident #11 not receiving the services necessary to maintain physical health and resulted in serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/19 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 26, 2019.	D 273		

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D 299	Continued From page 67	D 299		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 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: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 8 ounces of milk was served twice daily to residents residing in the Assisted Living (AL) and the Special Care Unit (SCU). The findings are: Review of the facility's Weekly Menu for 09/18/19 - 09/21/19 and 09/23/19 - 09/24/19 revealed 8 ounces of milk was to be served to the residents at breakfast. Review of the facility's census revealed 61 residents resided in the facility on 09/18/19. Observation in the kitchen on 09/18/19 at 4:46pm revealed: -There was a one gallon container of whole milk with approximately 3/4 remaining stored in the small "prep" refrigerator in the kitchen. -There were five gallons of whole milk and five gallons of 2% milk stored in the walk-in	D 299		

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D 299	Continued From page 68 refrigerator. 1. Observation of the breakfast meal on 09/19/19 on the Special Care Unit (SCU) at 7:56am revealed: -There were 21 residents seated in the dining room for breakfast. -Resident were served water, tea and plated meals. -Milk was not served or offered to the residents to drink with their meal. Observation of the supper meal on 09/23/19 on the SCU from 5:04pm -5:31pm revealed: -There were 26 residents seated in the dining room for supper. -Residents were served water, tea and plated meals. -Milk was not served or offered to the residents to drink with their meal. Observation of the breakfast meal on 09/24/19 on the SCU side of the facility from 8:18am - 8:28am revealed: -There were 21 residents seated in the dining room for breakfast. -Residents were served water, tea and plated meals. -Two residents were served milk with cereal. -Milk was not served or offered to the other residents to drink with their meal. Interview with a resident residing on the SCU on 09/24/19 at 8:28am revealed: -The resident was not offered or served any milk at breakfast but liked milk. -The resident got milk "sometimes". Confidential interview with a staff revealed: -The residents on the SCU were never served	D 299		

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milk unless the resident was eating cereal.
-Staff did not want the residents to be served milk because it gave the residents diarrhea.

Interview with the Administrator on 09/24/19 at 2:37pm revealed:
-She expected milk to be served to the residents in the SCU.
-The residents might not understand if staff "just" asked the residents if they wanted milk.

Refer to the interview with a medication aide (MA) on 09/18/19 at 11:00am.

Refer to the interview with a cook on 09/24/19 at 8:52am.

Refer to the interview with the Special Care Unit (SCU) Director on 09/18/19 at 5:53pm.

Refer to the interview with the Administrator on 09/24/19 at 2:37pm.

2. Observation of the lunch meal on 09/20/19 on the Assisted Living (AL) section at 11:49am revealed:
-There were 21 residents seated in the dining room for lunch.
-Residents were served water, tea and plated meals.
-Milk was not served or offered to the residents to drink with their meal.

Observation of the supper meal on 09/23/19 on the AL side of the facility at 5:53pm revealed:
-There were 24 residents seated in the dining room for supper.
-Resident were served water, tea and plated meals.
-Milk was served to one resident.

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D 299	Continued From page 70 -Milk was not served or offered to any of the residents to drink with their meal. Observation of the breakfast meal on 09/24/19 on the AL side of the facility at 8:16am revealed: -There were 17 residents seated in the dining room for breakfast. -Resident were served water, tea and plated meals. -Two residents had approximately 8 ounces of milk in a beverage container and five residents had milk served with cereal -Milk was not served or offered to the other residents to drink with their meal. Interview with a resident residing on the AL side of the facility on 09/19/19 at 4:12pm revealed: -Residents were served milk in the morning but she was not served or offered milk. -The resident liked milk but did not know why she was not served or offered milk. -The resident was told by staff that she was a diabetic and did not need to have milk. -The resident had not asked to be served milk but would like milk to be offered. Interview with two personal care aides (PCAs) on the AL side on 09/23/19 at 6:05pm revealed: -There were two residents on the AL side that received milk. -Milk was not served or offered to all the residents twice daily, however, if a resident asked for milk then milk would be served. Refer to the interview with a medication aide (MA) on 09/18/19 at 11:00am. Refer to the interview with a cook on 09/24/19 at 8:52am.	D 299		

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D 299	Continued From page 71 Refer to the interview with the Special Care Unit (SCU) Director on 09/18/19 at 5:53pm. Refer to the interview with the Administrator on 09/24/19 at 2:37pm. Interview with a medication aide (MA) on 09/18/19 at 11:00am revealed the residents were not served a glass of milk during meals. Interview with the Special Care Unit (SCU) Director on 09/18/19 at 5:53pm revealed milk was served to residents at every meal. Interview with a cook on 09/24/19 at 8:53am revealed: -The facility's food was delivered weekly. -Each week, the facility received 8 gallons of milk per week. -The residents were supposed to be served milk at breakfast and lunch. -Milk was placed on a counter in the kitchen on ice in a bowl in case any residents requested milk. -The personal care aides (PCA) asked the residents if they wanted milk but, did not pour milk for every resident. -If milk was offered or served to all residents at the facility then the milk supply for the facility would be close to being used before the next delivery. Interview with the Administrator on 09/24/19 at 2:37pm revealed she expected milk to be served to the residents twice daily.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D 310		

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D 310	Continued From page 72 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: Noncompliance continues with increased severity resulting in detriment to the health, safety and welfare of residents. THIS IS A TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 resident sampled, (#13) who was diagnosed with difficulty swallowing and had an order for honey thickened liquids and a pureed diet. The findings are: Review of Resident #13's current FL-2 dated 05/13/19 revealed: -Diagnoses included Alzheimer's disease and neurocognitive disorder with behavioral disturbances. -There was an order for a regular, mechanical soft diet. -There was documentation the resident was constantly disoriented. -The resident's current level of care was documented as "SCU" (special care unit). Review of a subsequent primary care provider's (PCP's) order for Resident #13 dated 06/20/19 revealed there was an order for a regular chopped meat, soft/chopped vegetable diet and nectar thickened liquids with meals.	D 310		

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D 310	Continued From page 73 Review of Resident #13's PCP visit note dated 08/14/19 revealed: -The resident's past medical history included dysphagia. (Dysphagia is a medical term used to describe difficulty swallowing). -In the plan section of the note there was documentation that included dysphagia: the resident was on a chopped meats and chopped/soft vegetables with nectar thick liquids, "will look into" scheduling a swallow evaluation to determine if the resident could be upgraded to thin liquids or needs to continue thickened liquids. Review of a Physician's Consultation Report signed by a Speech Pathologist dated 08/19/19 for Resident #13 revealed: -The reason for the visit was for a Cookie Swallow. (A Cookie Swallow with x-ray is an X-ray test that takes pictures of the mouth and throat while swallowing various foods and liquids to determine if there was swallowing difficulty). -There was a handwritten note that included aspiration with nectar thickened and regular thin liquids. Review of Resident #13's PCP visit note dated 08/21/19 revealed: -A swallow study was scheduled in hopes of downgrading the resident to thin liquids. -The Speech Therapist (ST) called following the study and recommended downgraded the resident's diet to honey thick liquid and pureed foods. Review of an additional subsequent PCP order for Resident #13 revealed there was an order to change diet to a pureed diet due to aspiration and honey thick liquids dated 08/21/19.	D 310		

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D 310	Continued From page 74 Review of a Care Note for Resident #13 dated 08/19/19 revealed: -There was an entry that the resident was seen at a local hospital for a Cookie Swallow test. -The primary care provider requested a diet change to pureed, medications crushed due to possible aspiration precautions. 1. Review of the "Menus" "Week 3, Day 4, "Sep - 19", Monday" therapeutic diet spreadsheet revealed the dinner meal for a pureed diet consisted of a pureed cheeseburger, pureed creamed corn, pureed vegetable of the day, and a pureed iced brownie. Observation during the dinner meal in the Special Care Unit (SCU) on 09/18/19 at 5:21pm revealed: -Three personal care aides (PCAs) were passing out beverages, plated food and desserts to the residents. -Resident #13 was dragging his spoon across a small amount of pureed food left in his plate. -Resident #13 had approximately 1/4 cup serving of pineapple tidbits. -Resident #13 began eating the pineapple tidbits which were not pureed. -Resident #13 was chewing the pineapple tidbits. -There were two PCAs in the dining room. -After prompting, a PCA removed the pineapple tidbits and told Resident #13 she would get him another dessert. -Resident #13 had approximately four pineapple tidbits left in the serving bowl. -Resident #13 continued to chew on the tidbits that were still in his mouth. -Resident #13 was served applesauce. -Resident #13 ate 100% of the applesauce. -Resident #13 did not have any difficulty with swallowing or coughing noted throughout the meal.	D 310		

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D 310	Continued From page 75 Interview with a PCA that served the food to the residents in the SCU during the dinner meal on 09/18/19 at 5:32pm revealed: -Resident #13 was on a pureed diet. -She did not serve Resident #13 his dessert and had not noticed the resident being served the pineapple tidbits. -Resident #13 could not have pineapple tidbits unless it was pureed. Interview with a second PCA that served the food to the residents in the SCU during the dinner meal on 09/18/19 at 5:35pm revealed: -Resident #13 was on a pureed diet. -She served Resident #13 his dessert and "didn't think about it" when she served the resident the pineapple tidbits. Interview with the cook on 09/20/19 at 2:50pm revealed: -Resident #13 was on a pureed diet with thickened liquids. -During meal service, the dietary staff were responsible for plating the correct foods on each of the residents' plate. -When residents' food was plated, the PCAs were told what plates go to each resident by kitchen staff. -Routinely. the "wait staff" in the kitchen were responsible for opening any cans of fruits or applesauce and plating that dessert to be served to the residents. -On 09/18/19, he had prepared brownies for the residents' dessert, however, the brownies had been overcooked and not used for the meal. -If the brownies were used the resident could have received a pureed brownie. -On 09/18/19, the wait staff had not opened a container of applesauce to serve to the residents	D 310		

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on pureed diets and Resident #13 was "accidentally" given the wrong dessert,
-It was not okay for Resident #13 to have pineapple tidbits, because the resident could choke.
-Pureed foods should not be watery and thin when pureed and should be in a smooth baby food type texture.
-When he pureed foods that had a lot of watery texture, he added extra bread, instant potato flakes or extra meat to make the food have a smooth paste type texture.

Review of the "Menus" "Week 4, Day 2, "Sep - 23" therapeutic diet spreadsheet revealed the dinner meal for a pureed diet consisted of a pureed shredded pork sandwich, ½ cup of mashed potatoes, ½ cup of pureed braised cabbage and a 2x3 square of pureed chocolate cake.

Observation in the dining room on 09/23/19 at 5:36pm revealed:
-Resident #13 was served a vegetable that was in finely ground pieces and surrounded by a milky liquid with his pureed meal.
-Resident #13 had not eaten any of the vegetable.

Interview with the cook on 09/23/18 at 5:39pm revealed:
-The finely ground pieces of vegetable served to Resident #13 was pureed creamy coleslaw.
-He added extra cabbage to thicken the coleslaw.
-He did not notice the pureed therapeutic diet menu did not include the creamy coleslaw for pureed diets.
-The facility had step by step instructions on how to puree all foods.
-He would puree Resident #13 another vegetable.

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D 310	Continued From page 77 Review of the facility's "Blueprint" menu for pureed braised cabbage in the kitchen revealed there were instructions to prepare according to the regular recipe, measure the desired number of servings into the food processor, blend until smooth, add water if product needs thinning and commercial thickener if product needs thickening. Observation in the kitchen on 09/23/19 at 5:39pm revealed the Administrator from a sister facility entered the kitchen and told the cook that raw vegetables could not be served to Resident #13 and that all foods must be in a pureed smooth, creamed potato consistency. Observation of Resident #13 on 09/23/19 at 6:00pm revealed: -The resident was served mashed potatoes in place of the creamy coleslaw. -The resident ate 100% of the mashed potatoes. -The resident did not have any coughing or gagging while eating. Interview with the Administrator from a sister facility and the SCU Director on 09/20/19 at 3:01pm revealed: -Dietary staff were responsible to ensure all food was plated correctly and in the correct consistency as ordered before each plate left the kitchen. -The dietary staff received re-education regarding therapeutic diets on 09/18/19. Telephone interview with Resident #13's primary care provider (PCP) on 09/26/19 at 4:05pm revealed the pureed diet was for ease of eating due to Resident #13's poor dentition. The DM was not available for interview on	D 310		

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D 310	Continued From page 78 09/20/19 through 09/26/19. Telephone interview with the Speech Therapist (ST) who performed Resident #13's swallow testing on 09/22/19 at 4:50pm revealed: -The resident had a short attention span during the testing due to his mental cognition. -The resident had a difficult time chewing and swallowing while eating and it took the resident "forever" to swallow a small piece of cookie during the Cookie Swallow test. -The resident "silently"aspirated thin and nectar thickened liquids during the test. -A "video" was used during the testing and the resident was able to clear some of the liquids out of his airway. -The resident would be at risk for breathing in food particles that were unchewed or liquids that could go down into his airway because of the resident's cognition and alertness. -A pureed diet was the most appropriate diet for the resident. -The resident was at risk for choking or suffocation if served chunks of food such as pineapple tidbits. -The resident could pocket foods that were not pureed and could choke while asleep. -The resident was at risk for aspiration pneumonia when not served pureed food because of his swallowing limitations, age and cognition level. (Aspiration pneumonia is a lung infection that develops after inhaling food, liquid, or vomit into the lungs and if unable to cough up the aspirated material bacteria could grow in the lungs causing an infection). Refer to the interview with the Administrator on 09/24/19 at 2:37pm. 2. Interview with the Dietary Manager (DM) on	D 310		

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D 310	Continued From page 79 09/18/19 at 9:45 am revealed: -Resident #13 received thickened liquids. -Dietary staff were not responsible for mixing Resident #13's beverages with the thickening agent because the medication aides (MAs) mixed the thickener with the resident's beverages. -The thickener was kept on the medication cart. Observation of the medication room on the Special Care Unit (SCU) on 09/18/19 at 11:00am revealed: -There was a large container of a thickening agent with a pharmacy dispensing label for Resident #13. (A thickening agent is a powder that is dissolved in liquids to thicken thin liquids to a desired consistency when thin liquids were difficult to swallow, to prevent choking and prevent liquids from entering the lungs during the swallowing process). -There was a red sticker over the dispensing label directions, "Directions changed refer to chart". -There was a dual ended blue measuring device inside of the container. One end was labeled as one tablespoon and the other end labeled one teaspoon. -There were labeled directions including "t" = teaspoon, "T" = tablespoon and instructions there were 3 teaspoons in one tablespoon. -The manufacturer's label had directions for a honey thick consistency to add 4- 5 teaspoons (t) to water, apple juice. cranberry juice, and coffee/tea, 5t-5 ½t to low fat milk and nutritional drink supplements and 3 1/2t - 4t to orange juice, to every 4 ounces of liquid. -One T of the thickening agent should be added to 4 ounces of food when pureeing. -There were instructions that the amount of the thickening agent used may need to be adjusted to suit the thickness requirements.	D 310		

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D 310	Continued From page 80 Observation of a MA on 09/18/19 at 11:00am revealed: -There was one beverage container of tea and another with water without ice with approximately 6 to 8 ounces of fluid in each beverage container. -The MA referred to the manufactured labeled honey thick instructions on the thickening agent container and added 4T (for a total of 12 teaspoons) to the tea and water, then stirred each of the beverages until dissolved. -The tea and water in each beverage container were a pudding thickened consistency. Interview with the MA on 09/18/19 at 11:10am revealed: -She knew that ice could not be added to thickened liquids. -Resident #13's fluids should be mixed to a honey thickened consistency. -She was not sure why but Resident #13's tea thickened more to a pudding consistency than the water. -She thought there was 8 ounces of fluid in each beverage container. -She did not measure Resident #13's fluids because dietary staff were responsible for preparing and measuring the resident's beverages. -The "t" on the labeled manufacturer's instructions meant tablespoons. -Resident #13 "ate" his beverages. -Honey thickened liquids should be in a loose pudding like consistency. -Resident #13 was previously on nectar thickened liquids but was changed in August 2019 after a Cookie Swallow test was done because he was getting "a little strangled" while eating. Observation of Resident #13 during the lunch meal on 09/18/19 at 11:25am revealed:	D 310		

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D 310	Continued From page 81 -There was a spoon in the resident's beverage that stood straight up in the thickened liquids. -Resident #13 was sitting in a wheelchair in the hallway close to the entrance door of the dining room on the SCU. -Staff were encouraging the resident to go into the dining room for lunch, however, the resident reported "I don't want no food". -Staff attempted to assist and encourage the resident to eat, however when staff offered the resident any food or beverage, the resident would turn his head. Observation of a second MA on 09/18/19 at 5:10pm revealed: -There was one beverage container of tea and another with of water without ice with what appeared be approximately 6 to 8 ounces of fluid in each beverage container. -The MA added 2Ts of the thickening agent each to the tea and water, then stirred until dissolved. -The MA added approximately ½T more of thickening agent to the tea and water, then sprinkled more into each beverage. -The consistency was honey thick. Interview with the second MA on 09/18/19 at 5:17pm revealed: -She was trained by another MA to add 5 scoops when adding thickener to beverages but, thought that was "a bit much". -She had not received any training from the facility on how to prepare thickener to beverages other than instructions from another MA. -No one had ever observed her preparing thickeners to beverages. -She was not sure how much tea or water was poured into the glasses for Resident #13 because dietary prepared Resident #13's beverages. -When she mixed Resident #13's thickener, she	D 310		

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would "Eye it out" to the consistency of honey thick.
-The "scoop" in the thickener container did not have any measuring increments.

Interview with two cooks on 09/20/19 at 2:50pm revealed:
-One cook had worked at the facility for almost one year and the other cook had worked at the facility for 2 years and in dietary one year.
-He had received dietary training from the dietary manager.
-Resident #13 was on an ordered pureed diet with thickened liquids.
-Dietary staff were responsible for pouring Resident #13's beverages.
-Dietary staff were told that the Resident #13's beverages should contain 8 ounces each.
-The beverage containers used were filled to a top rimmed area on the containers with Resident #13's beverages which was equivalent to 8 ounces.
-Dietary staff were trained by the dietary manager on how to measure liquids.

Observation of the cook on 09/20/19 at 2:50pm revealed:
-The cook used a measuring cylinder and measured 8 ounces of water at eye level.
-The cook poured the water into the beverage container up to the top rimmed area which was approximately 6 ounces of water leaving 2 ounces of the measured water in the measuring cylinder.

The DM was not available for interview on 09/20/19 through 09/26/19.

Interview with the Special Care Unit (SCU) Director on 09/18/19 at 5:53pm revealed:

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D 310	Continued From page 83 -The MAs were responsible for preparing Resident #13's thickened beverages. -Dietary staff were responsible for measuring and pouring Resident #13's beverages. -The beverage containers used for Resident #13's beverages were 8 ounce beverage containers. -The facility provided all of the MAs re-education with a return demonstration on how to properly mix thickener to beverages in June 2019. -MAs were expected to follow the manufacturer's labeled directions when adding thickener to assure the beverages were mixed to the appropriate consistency accurately and by the ordered consistency. -Last Wednesday, (09/11/19) he watched the MA who prepared Resident #13's thickened beverages today (09/18/19) at 11:00am and there were no issues with the preparation of Resident #13's beverages. -Honey thickened beverages should "barely move", in a slow dripple consistency when poured from a spoon. -He observed meals being served to residents several times a week and had not seen any concerns with Resident #13 receiving his honey thickened liquids. Confidential interview with a staff revealed: -The facility had not provided any specific training prior to yesterday (09/18/19) on how to prepare and mix thickener to beverages other than verbally told by the Administrator and the SCU Director to follow the instructions on the label. -The staff was not sure why but the thickness of Resident #13's beverages would be different even when following the manufacturers labeled directions and required adjustments to the amount of the thickening agent used to achieve a honey thick consistency.	D 310		

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D 310	Continued From page 84 Telephone interview with Resident #13's primary care provider (PCP) on 09/26/19 at 4:05pm revealed: -Thickened liquids were important for Resident #13 because he had aspiration issues. -Resident #13 was recently downgraded from nectar thick to honey thick liquids due to having continued leakage when he was evaluated by the speech therapist. Based on observations, interviews and record reviews, it was determined Resident #13 was not interviewable. The DM was not available for interview on 09/20/19 through 09/26/19. Telephone interview with the Speech Therapist (ST) who performed Resident #13's swallow testing on 09/22/19 at 4:50pm revealed: -The resident was tested during the Cookie Swallow using thin, nectar and honey thickened liquids. -The resident had a short attention span during the testing due to his mental cognition. -The resident "silently"aspirated thin and nectar thickened liquids during the test. -A "video" was used during the testing and the resident was able to clear some of the liquids out of his airway. -She made recommendations that Resident #13 should be served honey thickened liquids. Refer to the interview with the Administrator on 09/24/19 at 2:37pm. _____ Interview with the Administrator on 09/24/19 at 2:37pm revealed: -Resident #13 was at risk for aspiration and had a	D 310		

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D 310	Continued From page 85 weak cough reflex. -She monitored meals in the Special Care Unit (SCU) and there had not been any incidences with Resident #13 coughing or choking. -She expected all meals and beverages and food to be served to residents as ordered. _____ The facility failed to assure therapeutic diets were served as ordered for Resident #13 who was not able to swallow thinned liquids or chew foods safely, was ordered on a pureed diet and honey thick liquids related to risks of choking and potential aspiration and was observed receiving thin liquids in a serving of food, pineapple tidbits and finely ground food during two meal observations. The facility's failure to assure Resident #13 received honey thick liquids and pureed foods posed a risk of pneumonia or choking which was detrimental to the health and safety of the resident, which constitutes a Type B Violation. _____ A Plan of Protection (POP) was submitted by the facility in accordance with G.S. 131D-34 on 09/25/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 86 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure 3 of 3 sampled residents were protected from harm and injury from a male resident who had aggressive behaviors which resulted in Resident #9 being pushed out of her wheelchair and had to be transported to the emergency room for evaluation, Resident #18 had been bruised as a result of being hit and Resident #4 had been kicked out of her wheelchair. The finding are: 1. Review of Resident #9's current FL-2 dated 11/15/18 revealed: -Diagnoses included Alzheimer's disease, osteoporosis and rheumatoid arthritis major. -There was documentation the resident was intermittently disoriented. Review of Resident #9's Resident Profile/Care Plan dated 11/15/18 revealed: -The resident was always disoriented, had significant memory loss and had to be directed. -The resident was totally dependent on staff for bowel and bladder needs and required extensive assistance from staff for bathing, dressing, ambulation and transferring needs. Review of the Care notes for the named male resident dated 07/18/19 revealed: -The male resident was accused of kicking Resident #9 out of her wheelchair. -Resident #9 was taken to the emergency room as a result of the incident. -The resident was placed on 15 minute checks due to behavioral issues.	D 338		

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D 338	Continued From page 87 Review of Resident #9's Care Notes dated 07/18/19 revealed: -The resident was sitting in her wheelchair in the hallway when staff reported the resident fell out of her wheelchair and hit her head. -The resident's primary care provider (PCP) and power of attorney (POA) were notified. -The resident was transported to the emergency room. Review of an Emergency Department Discharge Instruction form for Resident #9 dated 07/18/19 revealed: -The resident's diagnosis was listed as a fall. -The CT Scan (A test using X-rays and a computer to create pictures of organs, bones, and other tissues) did not show any emergency findings. -There was documentation for the resident to follow-up with the PCP. Confidential interview with a staff revealed: -A male resident pushed Resident #9 out of her chair in the hallway in the middle of the special care unit (SCU). -The staff did not remember the date of the incident. -Resident #9 had to go to the emergency department (ED) as a result of the push from the male resident. -The MA had called emergency responders. -The male resident was not placed on 15 minute checks or one on one checks. Telephone interview with a former staff on 09/25/19 at 9:30am revealed: -She witnessed the male resident push a resident out of chair which resulted in the other resident going to the emergency room, she did not know	D 338		

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the date.
-Neither resident was placed on one on one checks, she was not sure why.
-She witnessed the male resident kick another resident out of her wheelchair, the other resident was fine and did not require medical intervention, she did not know the date.
-Neither resident was placed on one on one checks, she did not know why.
-The management team was aware of all incidents/accidents involving the male resident's aggressive behavior.
-The male resident was aggressive the entire time she was employed at the facility, and nothing was done to protect the other residents.

Interview with the Special Care Unit (SCU) Director on 09/23/19 at 3:43pm revealed when a resident showed aggression, they were placed on one on one watch until they were no longer showed signs of aggression.

2. Review of Resident #18's FL2 dated 04/10/19 revealed:
-Diagnoses included Alzheimer's/dementia, hypertension, and schizophrenic disorder paranoid.
-The resident was constantly disoriented.
-The resident was ambulatory.
-The resident wandered.
-The recommended level of care was documented as special care unit (SCU).

Review of Resident #18's Resident Register revealed:
-The resident was admitted to the facility on 07/06/06.
-The resident needed assistance with dressing, bathing, and nail care.

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D 338	Continued From page 89 Review of Resident #18's Resident Profile/Care Plan dated 05/30/19 revealed: -The resident was not oriented to person, time, or place. -The resident was ambulatory. -The resident was totally dependent on staff for toileting and incontinence care. -The resident was not aggressive. Interview with a personal care assistant (PCA) on 09/23/19 at 3:26pm revealed: -Resident #18 was hit by a male resident a week ago. -Resident #18 received a bruise as a result of the hit from the male resident. -The male resident had hit other residents in the past. -The medication aide (MA) was aware and she had tried to redirect the male resident after he hit Resident #18. -An accident/incident report should have been done but she was unsure if one had been completed. Review of Resident #18's record on 09/24/19 at 11:45am revealed: -There was no documentation of an accident/incident report for the resident in the month of September 2019. -There was no documentation the resident had an injury in September 2019. Interview with the Chief Operating Officer (COO) on 09/24/19 at 11:47am revealed: -When an accident/incident occurred the PCA was supposed to contact the supervisor. -Then the supervisor was supposed to complete an accident/incident report. -Then the supervisor was supposed to give the accident/incident report to the Administrator.	D 338		

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-The Administrator was responsible for signing the accident/incident report and sending the report to the Department of Social Service (DSS).
-When a resident was found to need more supervision the supervision plan would be individualized to have met the residents needs at this time of the accident/incident.
-If 15 minute checks were implemented it would have remained in effect for 72 hours.
-After 72 hours she would determine if there was still a risk or need for the resident to have remained on 72 hour checks.

Confidential interview with a staff member revealed, when residents got into fights, the policy was to separate the residents from each other, notify the doctor, notify the mental health provider, watch the residents for 72 hours.

Interview with the Activity Director on 09/24/19 at 10:30 am revealed management at the facility had not done anything to protect other residents from the male resident.

3. Review of Resident #4's current FL-2 dated 01/09/19 revealed:
-Diagnoses included dementia, anxiety, chronic pain syndrome, depression, hypertension and malaise.
-There was documentation the resident was constantly disoriented and wandered.

Review of Resident #4's Resident Profile/Care Plan dated 06/20/19 revealed:
-There was documentation the resident was sometimes disoriented, her memory was forgetful, needed reminders and wandered.
-There was documentation the resident was ambulatory with the use of a wheelchair.
-There was documentation the resident was not

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D 338	Continued From page 91 aggressive and to monitor for any changes. Based on observations, interviews, and record review, Resident #4 was not interviewable. Confidential interview with a second staff revealed: -A male resident kicked Resident #4 out of her wheelchair because she had run over his foot. -The staff did not know the date of the accident. -Resident #4 was fine after she was kicked out of her wheelchair. -Resident #4 had got back into her wheelchair and went to her room. -The MA was aware of the accident when it occurred. -The staff member had no indicated that an accident/incident report was completed. -The male resident and Resident #4 were not placed on one on one checks. Interview with the Administrator on 09/26/19 at 11:26am revealed: -She did not know Resident #4 was pushed out her wheelchair by a male a resident. -She was aware that a male resident had kicked the arm of Resident #4's wheelchair. -The MA is expected to contact the PCP, the mental health provider, family of both residents involved in the accident, an accident/incident report should be completed for both residents involved. The facility failed to protect 3 of 3 sampled residents from abuse by another resident known to exhibit aggressive behaviors resulting in Resident #9 being pushed out of her wheelchair and requiring emergent hospital evaluation, Resident #18 being hit and bruised, and Resident #4 being knocked out of her wheelchair . The	D 338		

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D 338	Continued From page 92 facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 338		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there was an accurate accounting of and readily retrievable record of controlled substances including an opioid pain reliever for 1 of 9 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 03/18/19 revealed diagnoses included dementia, benign prostate hypertrophy, hypertension and	D 392		

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D 392	Continued From page 93 Raynaud's syndrome. Review of a hospital discharge prescription order dated 07/25/19 for Resident #5 revealed an order for Percocet 5/325mg every six hours as needed (PRN) for nose pain. (Percocet is a opioid based pain reliever.) Review of a Primary Care Provider (PCP) order dated 08/21/19 for Resident #5 revealed an order to discontinue Percocet because it was not needed. Review of Resident #5's July and August 2019 electronic medication administration records revealed: -There was an entry for Percocet 5/325mg every six hours PRN for nose pain. -There were no doses documented as administered from 07/25/19 through 08/22/19. Review of a controlled drug record for Resident #5 revealed: -Resident #5's name and instructions for Percocet 5/325mg every six hours PRN for nose pain was handwritten on the form. -There was documentation 20 tablets were received on 07/25/19. -There were no tablets documented as administered, discarded or returned to the pharmacy. Observations of medications available for administration for Resident #17 on 09/19/19 at 11:30am revealed there was no Percocet for the resident. Upon request on 09/19/19, there was no documentation the Percocet for Resident #5 was returned to the pharmacy.	D 392		

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D 392	Continued From page 94 Telephone interview with a pharmacist at the facility's back up pharmacy on 09/19/19 at 5:18pm revealed 20 Percocet 5/325mg tablets were dispensed on 07/25/19 for Resident #5. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/25/19 at 9:36am revealed: -The pharmacy called the Percocet prescription for Resident #5 into the backup pharmacy on 07/25/19 at staff request. -The contracted pharmacy did not dispense any additional Percocet tablets for Resident #5. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/19/19 at 4:20pm revealed there was no record of return for Resident #5's Percocet dispensed on 07/25/19. Interview with a medication aide (MA) on 09/24/19 at 8:48am revealed: -She remembered Resident #5 being on Percocet and then it was discontinued. -There were 20 Percocet tablets dispensed in a prescription bottle from the back up pharmacy. -She was the MA on duty when the Percocet for Resident #5 was discontinued. -She completed a pharmacy return slip and placed the slip in the return tote but did not remove the Percocet from the medication cart. -The MA who worked third shift was responsible for removing the medication from the cart and placing it in the return tote when the pharmacy delivery person came to the facility. Interview with the Special Care Unit (SCU) Director on 09/24/19 at 10:05am revealed: -He did not know the disposition of Resident #5's	D 392		

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D 392	Continued From page 95 20 Percocet tablets was not documented after being received by the facility. -There was no return slip for Resident #5's Percocet; there was no documentation of what happened to Resident #5's Percocet. -The unknown disposition of Resident #5's 20 Percocet tablets was not reported to the pharmacy or law enforcement because he did not know the Percocet was unaccounted for. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable. Confidential interview with a staff revealed: -There were frequent issues with controlled drugs at the facility. -There were times controlled drugs would go missing and then reappear. -If someone checked they would see there were many wasted narcotics, too many to be dropped, punched in error or refused. -Staff believed the Administrator was aware because a staff had asked for all staff to be drug tested. Confidential interview with a second staff: -There were MAs that could get rid of controlled drug records. -Some MAs would leave controlled drugs that were supposed to be returned on the medication cart then take them out without signing them out. -Then no one could find the return slip or the controlled drug record. Interview with the Special Care Unit (SCU) Director on 09/24/19 at 10:05am revealed: -The facility used pharmacy return slips specifically for medications returned to the pharmacy.	D 392		

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D 392	Continued From page 96 -MAs were responsible for completing the pharmacy return slip. -The return slip and the controlled drug were kept in the lock box on the medication cart until picked up by the pharmacy delivery person. -MAs used to place the return slip in the pharmacy return tote; now they used a sticky note in the return tote as a reminder. -The pharmacy return slip was a carbon copy which was signed by the MA on duty and the pharmacy delivery person. -The pharmacy delivery person kept a copy and left a copy in the facility. Interview with the Administrator on 09/24/19 at 2:36pm revealed: -The controlled drug process included faxing the order to the pharmacy and the MA on duty signed for at delivery after confirming amount delivered. -Controlled drugs were delivered with a controlled drug record from the pharmacy. -The MA on duty documented the amount received on the controlled drug record after verifying the amount. -MAs documented tablets administered on the controlled drug record; any wasted tablets were documented on the back of the controlled drug record with two staff signatures. -MAs completed a return slip for any controlled drugs being returned to the pharmacy. -The completed return slip was placed in the return tote and MA pulled the controlled drug off the medication cart when the pharmacy delivery person came to the facility. -The return slip was a carbon copy, the facility kept a copy and a copy went to the pharmacy. -The Resident Care Coordinator (RCC) or SCU Director was responsible for checking to make sure the controlled drug process was followed daily.	D 392		

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D 392	Continued From page 97 Telephone interview with the SCU Director on 09/26/19 at 9:58am revealed there was not a process to oversee the controlled process from delivery through documentation of administration, waste or return to pharmacy.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5-day requirements for 2 of 2 sampled resident (#1, #17) who sustained bruises of unknown origins. The findings are: 1. Review of Resident #1's current FL-2 dated 03/25/19 revealed diagnoses included chronic kidney disease stage 3, hypertension, hypothyroidism, osteoarthritis and hyperlipidemia. Observation of Resident #1 in the Special Care Unit (SCU) common area on 09/18/19 at 11:19am revealed a large bruise on the right wrist that was reddish, purple in color.	D 438		

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D 438	Continued From page 98 Interview with a personal care aide (PCA) on 09/18/19 at 4:36pm revealed: -Another PCA completed a skin assessment for Resident #1's bruise on the right wrist. -She was not sure what day the skin assessment was completed. -The Supervisor checked the skin assessments and signed off on them showing they had been reviewed. -She was not able to locate the skin assessment completed for Resident #1's bruise on her right wrist. Interview with a Supervisor on 09/19/19 at 7:28am revealed: -The bruise on Resident's #1's right wrist had been there for a while. -She wasexpected to look at bruises that were found on residents and document the bruises in the Resident's chart, notify the doctor and make the SCU Director aware of any bruises. -She and other staff were responsible for notifying the administrator of bruises that occurred with residents. -She had not notified anyone of the bruise located on Resident #1's right wrist. Interview with a second PCA on 09/19/19 at 1:15pm and 09/20/19 at 10:32am revealed: -The bruise on resident #1's right wrist was not there on 09/14/19 during first shift. -She saw the bruise on 09/15/19; it was big and red. -She reported the bruise on Resident #1's right wrist to a supervior on 09/15/19. -She completed a skin assessment on 09/15/19 and gave it to a supervisor. Interview with a second supervisor on 09/19/19 at	D 438		

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D 438	Continued From page 99 1:24pm revealed: -After a skin assessment was completed and given to a supervisor, the supervisor would sign the assessment to acknowledge it was reviewed and would notify the SCU Director. -She was notified of the bruise on resident #1's right wrist by a PCA on 09/15/19. -She looked at the bruise and it was red on 09/16/19 and 09/17/19. -She did not know how Resident #1 got the bruise on her right wrist. -"It was not there one day and then overnight it was there." -She notified the SCU Director of the bruise on Resident #1's right wrist (no date specified). Interview with the second PCA on 09/20/19 at 10:32am revealed: -She worked on 09/17/19 and noticed the bruise had gotten bigger and was a reddish, purple color. -She reported the bruise to Resident #1's right wrist to a supervisor again on 09/17/19. -"I cannot say how the bruise got there." Interview with the SCU Director on 09/20/19 at 11:51am revealed: -The process for skin assessments to be reviewed was once a supervisor received the assessment they were to be placed into the shower book -The Administrator and the SCU Director reviewed the skin assessments. -The physician was contacted depending on the severity of any bruises. -The skin assessments were reviewed weekly by the SCU Director. -If an investigation needed to be done the corporate office would conduct the investigation. -The SCU Director was not aware of any bruises	D 438		

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D 438	Continued From page 100 on Resident #1's right wrist. Interview with the Administrator on 09/23/19 at 10:24 am revealed: -The PCAs were to report bruises to the supervisor. -The supervisor would check the residents' bruise, if anything needed to be done the supervisor would contact the SCU Director. -Any skin breakdown or redness found during the skin assessment would be reported to the SCU Director. -The skin assessments were to be reviewed daily. -If there were any bruises of unknown origin the SCU Director would contact the physician and responsible party and would coordinate any other services that were needed for the resident at the time. -"I never review the skin assessment/shower book." -She was not aware of the bruise on resident #1's right wrist. -She did not know bruises of unknown origin needed to be reported to HCPR. 2. Review of Resident #17's current FL-2 dated 04/17/19 revealed: -Diagnoses included dementia, hypothyroidism, vitamin B12 deficiency and osteoarthritis of the knee. -Resident #17 was constantly disoriented and semi-ambulatory. Observation on 09/19/19 at 4:36pm revealed: -A personal care aide (PCA) entered Resident #17's room to check for bruising and did not say anything to the resident. -The PCA pulled back the cover, again without saying anything to the resident. -Resident #17 attempted to pull the covers back	D 438		

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D 438	Continued From page 101	D 438		

up, whimpered and curled into a semi-fetal position.
-There were similar large purple/red bruises on the backs of Resident #17's hands.

Interview with the PCA on 09/19/19 at 4;36pm revealed:
-Resident #17 was okay, that was what she usually did.
-She would go back later and attempt to change Resident #17's incontinence brief.
-Resident #17 had bruises on the back of her right hand because she was at the hospital and had blood work done; she did not remember when the resident went to the hospital.

Review of care notes, incident reports, transportation notes and hospital discharge instructions for Resident #17 revealed there were no incidences of Resident #17 being taken to the hospital for laboratory work or being hospitalized in September 2019.

Telephone interview with Resident #17's Power of Attorney (POA) on 09/26/19 at 2:21pm revealed:
-She noticed the bruises on Resident #17's hands.
-She did not know "if it's (bruises) from them (staff) grabbing her (Resident #17) by the hands or what."
-The bruises would come and go; get bad, then go away and then come back.
-Sometimes there were bruises up and down Resident #17's arms.
-She asked the staff and they did not know where the bruises came from.
-She "very seldom saw her (Resident #17) without bruises on her hands."
-Resident #17 was not able to say if someone was mistreating her and the POA did not know if

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D 438	Continued From page 102 Resident #17 was being mistreated. Interview with a second PCA on 09/20/19 at 11:45am revealed: -She noticed the bruises on Resident #17's hands on 09/19/19; she did not know how the resident got the bruises. -She completed a skin assessment sheet and gave it to the medication aide (MA)/Supervisor on duty on 09/19/19. Observation on 09/25/19 at 6:13pm revealed: -A PCA assisted Resident #17 to stand from being seated in the common area. -The PCA took Resident #17 by the hands, placing her hand under the resident's hands with her thumbs on the top of Resident #17's hands. Interview with the PCA on 09/25/19 at 6:13pm revealed: -Resident #17 needed prompting and guidance to walk to the dining room and her room. -Resident #17 would take staff's hands and walk with them if staff put their hands out for her. Confidential interview with a staff revealed: -Staff was "tired and burnt out" and there was not enough staff and staff were not properly trained to handle residents. -It was possible that bruises on residents' arms and hands came from being mishandled by staff. -Staff had seen other staff grab residents at the upper arm area which was a sensitive area due to the loss of subcutaneous fat. Telephone interview with a MA/Supervisor on 09/26/19 at 9:15am revealed: -She knew about the bruises on Resident #17's hands and she had documented the bruises on 09/03/19.	D 438		

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D 438	Continued From page 103 -She considered the bruises "transfer bruises" from PCAs assisting Resident #17 to get up. -She reported the bruises to the Special Care Unit (SCU) Director and the Administrator, but she could not remember when. Telephone interview with the SCU Director on 09/24/19 at 10:05am revealed: -He did not know about bruises on Resident #17's hands. -Resident #17 was elderly and bruised easily. -There was no Health Care Personnel Registry (HCPR) for the bruises on Resident #17's hands. -He expected staff to report bruises to the MA/Supervisor, himself or the Administrator. -He and/or the Administrator notified the corporate office of any needed HCPR reports. -The corporate office completed all HCPR reports and investigations. Interview with the Management Liaison on 09/25/19 at 3:01pm revealed any investigations for bruises of unknown origin would have been done by the corporate office and the person responsible was out of the office until 09/30/19. Based on observations, interviews and record reviews, it was determined Resident #17 was not interviewable.	D 438		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and	D 465		

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D 465	Continued From page 104 second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Noncompliance continues with increased severity resulting in substantial risk of neglect and serious injury. THIS IS A TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of residents residing in the Special Care Unit (SCU) for 16 of 36 shifts sampled for 12 days in August and September 2019. The findings are: Review of the facility's 2019 license from the Division of Health Service Regulation revealed the facility was licensed for 122 beds with a special care unit with a capacity of 50 beds. Interview with a second MA/Supervisor on 09/17/19 at 7:46am revealed there were 28 residents on the SCU. Observations on the SCU on 09/17/19 from 7:30am until 7:52am revealed: -At 7:30am, there were four residents sitting in wheelchairs at the center of the main hallway; one of the residents had a chair alarm. -There was a medication aide (MA) braiding one of the resident's hair; the MA left after several minutes.	D 465		

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-At 7:43am, a personal care aide (PCA) brought a fifth resident to the center of the main hallway then went back down the hall leaving the five residents with no staff present.
-At 7:46am, a MA/Supervisor for the SCU came from the end of the men's hall and went to the medication room; there were seven residents in the main hallway and common area with no staff present.
-At 7:50am, there were seven residents in the main hallway and common area, and an additional five residents in the dining room with no staff present.
-At 7:52am, a PCA was present in the common area.

Interview with a MA/Supervisor on 09/17/19 at 7:30am revealed:
-There were three personal care aides (PCAs) and one MA/Supervisor on the SCU.
-She did not know where the first shift MA/Supervisor for the SCU was.

Interview with a MA on 09/17/19 at 7:30am revealed she was not the MA/Supervisor for first shift; she worked third shift and had just finished counting medications.

Interview with the first shift SCU MA/Supervisor on 09/17/19 at 7:46am revealed:
-She was the MA/Supervisor for the SCU.
-She had been "down the hall" and declined to give specifics.

Interview with the SCU Director on 09/18/19 at 5:07pm revealed:
-One staff was designated to monitor the hallways and residents in the common area at all times.
-The monitoring staff had been implemented last

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week (09/10/19).
-The only exception for monitoring staff not to be present in the hallway was when staff were immediately present with residents in the common area.
-The staffing ratio on the SCU was one staff for every eight residents and the MAs did four hours of aide duty.

Review of the punch record for staff and census report dated 08/09/19 revealed:
-The census was 31 residents.
-24.08 hours of staff time were required for third shift.
-20.08 hours were provided on third shift leaving the shift short 4 staff hours.

Review of the punch record for staff and census report dated 08/10/19 revealed:
-The census was 30 residents.
-24 hours of staff time were required for third shift.
-23.25 hours were provided on third shift leaving the shift short 0.75 staff hours.

Review of the punch record for staff and census report dated 08/11/19 revealed:
-The census was 30 residents.
-24 hours of staff time were required for third shift.
-23 hours were provided on third shift leaving the shift short 1 staff hour.

Review of the punch record for staff and census report dated 08/13/19 revealed:
-The census was 30 residents.
-24 hours of staff time were required for third shift.
-19.5 hours were provided on third shift leaving the shift short 4.50 staff hours.

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D 465	Continued From page 107 Review of the punch record for staff and census report dated 08/18/19 revealed: -The census was 30 residents. -30 hours of staff time were required for second shift. -26.625 hours were provided on second shift leaving the shift short 3.375 staff hours. Review of the punch record for staff and census report dated 08/19/19 revealed: -The census was 30 residents. -30 hours of staff time were required for first shift. -25.5 hours were provided on first shift leaving the shift short 4.5 staff hours. -24 hours of staff time were required for third shift. -18.625 hours were provided on third shift leaving the shift short 5.375 staff hours. Review of the punch record for staff and census report dated 09/02/19 revealed: -The census was 27 residents. -27 hours of staff time were required for first shift. -16.19 hours were provided on first shift leaving the shift short 10.81 staff hours. -21.6 hours of staff time were required for third shift. -There were 20.51 hours provided on third shift leaving the shift short 1.09 staff hours. Observations on 09/19/19 from 9:48pm until 10:05pm revealed: -At 9:48pm there were two staff sitting in a vehicle parked in the rear of the building near the rear entrance of the SCU. -The MA was in the medication room. -There was one PCA in the hallway on the SCU. -At 10:05pm two PCAs entered the SCU from the rear door.	D 465		

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D 465	Continued From page 108 Interview with the MA/Supervisor at 9:50pm revealed: -She was working with three PCAs; all three were in the building. -If two of the PCAs were not in the building, she did not know where they were. -She had been in the medication room writing her notes. Observation on the SCU on 09/19/19 at 9:51pm revealed: -There were no residents in the hallways on the SCU. -There were no residents in the common living areas on the SCU. -There was one female resident walking in her assigned room beside her bed. Confidential interview with a staff revealed the two PCAs were gone from the SCU for more than one hour. Interview with a PCA on 09/19/19 at 11:20pm revealed she was outside smoking a cigarette and had only been gone for 15 minutes on 09/19/19 at 10:05pm. Interview with the SCU Director on 09/24/19 at 10:05am revealed: -Staff were expected to tell the MA/Supervisor when they were taking a break. -Staff were permitted a 15 minute break after working two hours, then an unpaid 30 minute meal break followed by a second 15 minute break after two hours of work. -Staff were supposed to take breaks one at a time in 15 minute intervals; staff could not take both 15 minute breaks and meal break together. -Staff working 16 to 24 or more hours was not the	D 465		

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normal, but it had happened with increasing frequency over the last two weeks due to staff losses.

Review of the punch record for staff and census report dated 09/20/19 revealed:
-The census was 28 residents.
-28 hours of staff time were required for second shift.
-19.125 hours were provided on second shift leaving the shift short 8.875 staff hours.
-22.4 hours of staff time were required for third shift.
-19.125 hours were provided on third shift leaving the shift short 3.275 staff hours.
-A personal care aide (PCA) punched in at 8:08am and punched out at 11:00pm; the same PCA punched in at 11:01pm on 09/20/19 and punched out at 11:03pm on 09/21/19.

Interview with the PCA on 09/24/19 at 6:58am revealed:
-She worked 16 hours on 09/20/19 and then punched back in for 24 hours the same day.
-If the oncoming staff did not come in then she could not leave.
-She slept four hours each night (third shift) that she worked because she never knew how long she would have to stay the next day.

Review of the punch record for staff and census report dated 09/21/19 revealed:
-The census was 28 residents.
-28 hours of staff time were required for first and second shifts.
-22.25 hours were provided on first shift leaving the shift short 5.75 staff hours.
-18.625 hours were provided on second shift leaving the shift short 9.375 staff hours.
-22.4 hours of staff time were required for third

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shift.
-17.875 hours were provided on third shift leaving the shift short 4.525 staff hours.
-A PCA punched in at 7:06am and punched out at 10:33pm; the same PCA punched in at 11:38pm on 09/21/19 and punched out at 2:50pm on 09/22/19.

Interview with the SCU Director on 09/23/19 at 10:53am revealed:
-He worked as a MA for second shift on 09/21/19 and he was the only MA for the assisted living (AL) side and the SCU.
-He was responsible for administering medications to all the residents; there were a few residents that received medications two hours after the scheduled time.
-The SCU was short one PCA on 09/21/19 for first or second shift, he could not remember which.
-He was concerned about staffing because the facility had lost six additional staff since 09/17/19.

Review of the punch record for staff and census report dated 09/22/19 revealed:
-The census was 28 residents.
-28 hours of staff time were required for second shift.
-25.875 hours were provided on first second leaving the shift short 2.125 staff hours.
-22.4 hours of staff time were required for third shift.
-19.5 hours were provided on third shift leaving the shift short 2.9 staff hours.

Telephone interview with the Activity Director (AD) on 09/22/19 at 6:52pm revealed:
-She was working as the only medication aide in the building for second shift on 09/22/19.
-The second MA left saying the SCU Director was

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coming in to work second shift on 09/22/19.
-She contacted the SCU Director who said he was not able to come in.
-She tried to contact the Administrator but she had not answered the phone nor responded to text messages.
-She was responsible for administering medications to all of the residents on both sides.
-There were three personal care aides (PCAs) working on the SCU for second shift on 09/22/19.

Interview with a resident's family member on 09/17/19 at 9:45am revealed:
-Her visits were always unannounced, and she came at different times.
- A few months ago, she was notified that the resident was able to eat three other residents' food and her own food before staff realized what the resident had done.
-She did not know how the resident was able to eat all the food if she was being supervised by staff.

Observation of the SCU on 09/18/19 at 11:46am revealed:
-Residents were eating their lunch.
-The personal care aides (PCA) were going in and out of the kitchen to get residents their meals.
-A resident seated at the dining table closest to one of the exits had fallen asleep while eating her meal.
-The resident had started to lean over while she was asleep, the PCA was prompted that the resident was going to fall out of her chair as she had fallen asleep.
-After prompting, the PCA woke the resident up and told the resident to eat her lunch.

Interview with a PCA on 09/18/19 at 2:30pm

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revealed:
-The past few days there was just one or two PCAs working on the SCU.
-Three or four staff members were scheduled to work in the SCU but only one or two PCAs would show up.
-The medication aide (MA) was supposed to contact the Administrator or the SCU director that was on call the days that were short.
-When the SCU was short the SCU director or the Administrator were supposed to come in.
-No one in management came in to help when the SCU was short staffed.

Interview with a second PCA on 09/18/19 at 3:16pm revealed:
-The SCU was always short staffed.
-There was only two PCAs on most shifts.
-When the SCU was short staffed MA contacted the Administrator or the SCU director.
-When they were short staffed the Administrator and/or the SCU director did not come in to help with the shortage.

Confidential interview with a staff member revealed:
-The facility had been short staffed since May 2019.
-The staff at corporate did not listen to the staffing concerns and did not try to find ways to get more staff in the facility.
-Staffing in the SCU was horrible, "they are always short staffed".
-The facility did not have enough staff and staff call outs were the main reasons for the short staffing.
-The short staffing could have potentially caused residents in the SCU to be neglected.
-The staff could not pinpoint an exact incident that occurred due to short staffing.

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D 465	Continued From page 113 -The short staffing was impacting residents because "they were not getting the quality care they deserved." Confidential interview with a second staff member revealed the SCU was short staffed every weekend she worked for a while. Interview with a personal care aide (PCA) on 09/23/19 at 10:01am revealed: -There was only on PCA for first shift on 09/23/19. -Two of the third shift PCAs were told to stay; one of the PCAs had to leave so there were two PCAs to get residents up for breakfast. -All the residents made it to the dining room for breakfast. -There were four residents who needed assistance with eating breakfast. -She had to keep helping other residents get up and dressed, so the four residents had to wait in the dining room to eat. -A third PCA came in after breakfast. Interview with a MA/Supervisor on 09/18/19 at 4:05pm revealed: -She had been filling in for staffing shortages by working double shifts since August 2019. -She usually worked double shifts Monday through Thursday. -Three quarters of the facility staff worked double shifts to cover shortages from call outs and holes in the schedule. Confidential interview with a staff revealed: -The facility did not have enough staff. -There were days when staff would come to work but, would not know when they could go home because there would be no "relief" staff for them. Confidential interview with a second staff	D 465		

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revealed:
-The facility was short staffed recently.
-The SCU Director would leave the facility knowing the facility was short staffed.
-Staff tried to get coverage but sometimes could not find the coverage needed for that shift.

Confidential interview with a third staff revealed:
-The facility was short staffed on the SCU on second and third shifts.
-There were a lot of residents not getting proper care because there was not enough staff and the staff worked a lot of consecutive double shifts.
-Residents on the SCU had bad odors everyday from not being bathed.
-The SCU was supposed to have four PCAs on second shift; most of the time there were two PCAs.
-The third shift was supposed to have three PCAs; usually there were one to two PCAs.
-It was scheduled that way; there was not enough staff.
-The Administrator or SCU Director would say they were going to come in but did not.

Confidential interview with a fourth staff revealed:
-The facility did not have enough staff to take care of the residents.
-The Administrator "should not have fired all those staff, she just fired them."
-On 09/17/19, for third shift there were only two PCAs on the SCU.

Confidential interview with a fifth staff revealed:
-The facility had been short staffed since May 2019.
-There was no second shift MA and only one MA for third shift for the building.
-There were two full time MAs for first shift for the building.

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D 465	Continued From page 115 -Residents were not getting quality care because staff were tired and burnt out. -It was possible residents were getting injured from being mishandled because there were not enough staff and properly trained staff. -Staff were not properly trained to work with residents; all training was done online. -There were staff that frequently called in. Confidential interview with a sixth staff revealed: -Staffing was an issue at the facility. -When staff worked short staffed, residents were neglected. -Sometimes there was not enough staff who were properly trained and there was no access for needed equipment. -On 09/15/19, there was no access to a hydraulic lift so there were two residents staff could not get out of bed. Confidential telephone interview with a family member revealed: -Approximately 1 1/2 months ago the family member visited the facility and could not get anyone to respond to the doorbell to the SCU. -A staff member from the Assisted Living eventually assisted the family member by unlocking the entrance door to the SCU. -When the family member walked onto the SCU, the family member saw two staff standing outside talking with each other through a small window pane of the exit door. -The family member saw no other staff inside SCU. -The family member entered a common living room and found several residents standing in a common living area "staring" at a spilled beverage in the middle of the floor. -The family member thought the spilled beverage did not belong to a resident because it was in a	D 465		

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D 465	Continued From page 116 cup from a fast food restaurant. Interview with the Administrator on 09/23/19 at 11:27am revealed: -Staffing was an issue; she was aware of the shortages on the weekend of 09/21/19 and 09/22/19. -The shortages were due to staff calling out; staff were expected to find coverage when they called out. -The MA/Supervisor on duty was expected to call the SCU Director or her when they were short staffed. Second interview with the Administrator on 09/23/19 at 2:36pm revealed: -She did not keep track of the hours she worked as a direct caregiver; sometimes she worked as a MA and sometimes as a PCA. -Staff were entitled to two 15 minute breaks; one after two hours of work, lunch then a second 15 minute break after an additional two hours worked. -Staff were expected to let the MA/Supervisor know when they were taking a break. -MA meal breaks were paid breaks and all other staff had unpaid meal breaks. -It was possible staff worked 40 hours consecutively, but it was not normal practice. -The PCA who worked the 40 consecutive hours slept at the facility during those hours. -Staff were not able to consistently work that many hours and provide adequate care. -Not enough staff resulted in residents not getting the attention they needed. -If there were enough staff "there would be less falls and incidents, and more changes - if there were more incontinence changes and repositioning, there would be less skin breakdown."	D 465		

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D 465	Continued From page 117 -The MAs were "stretched beyond reasonable expectations for months and could not continuously work double shifts." -She believed overworked staff contributed to the number of call outs. Telephone interview with the Chief Operations Officer (COO) on 09/24/19 at 11:42am revealed: -She was aware of the short staffing issues at the facility. -The corporate office was diligently looking for caring staff who wanted to work at the facility. -The facility had lost an additional seven staff since 09/17/19. [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care & Supervision]. [Refer to Tag 270 10A NCAC 13F .0901(a) Personal Care & Supervision]. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care]. The facility failed to assure aide hours met the minimum requirements for a special care unit (SCU) and staff on duty were present at all times for 16 of 36 sampled shifts. The facility's failure to assure minimum aide hours for 16 shifts short staffed by 0.75 to 10.81 hours resulted in a lack of personal care assistance including toileting, incontinence care and repositioning with development of pressure ulcers that went unreported to the primary care provider until the wounds were stage III and the elopement of a resident from the SCU who was found half a mile from the facility requiring emergency room treatment for heat exhaustion and dehydration. The facility's failure to assure minimum staffing requirements on the SCU was detrimental to the	D 465		

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D 465	Continued From page 118 health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/24/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 465		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure there was a special care unit (SCU) coordinator on the SCU eight hours per day, five days a week leaving staff on the SCU unsupervised and lack of follow up on concerns and needs of the residents. The findings are: Interview with an Ombudsman on 09/23/19 at 4:20pm revealed: -She had not seen the SCU Director in the SCU very often.	D 466		

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D 466	Continued From page 119 -She usually could find him in the Administrator's office or the assisted living (AL) medication room. -She could not recall ever seeing him in his office on the SCU. Interview with a personal care aide (PCA) on 09/24/19 at 5:28 pm revealed that the SCU Director barely ever comes to the back hall (SCU). Confidential interview with a staff revealed: -The SCU Director made rounds on the SCU in the morning and only came back to the SCU if he had to bring some paperwork to the SCU. -The SCU Director did not use his office on the SCU, so it is mostly used for storage. Confidential interview with a second staff revealed: -Staff did not know where the SCU Director "fit in" on the chain of command. -The SCU Director was supposed to be the Resident Care Coordinator (RCC) but he was never in his office. -The SCU Director said he did a little bit everything (multiple job roles) at the facility. -One day the SCU Director was supposed to be the RCC then the next day he was supposed to be the Administrator, so staff did not know what the SCU Director really did. Confidential interview with a third staff revealed: -The SCU Director worked as direct care staff to cover staffing shortages evenings, nights and weekends. -The SCU Director would take time off from management duties to rest after working as direct care staff. Confidential interview with fourth staff member	D 466		

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D 466	Continued From page 120 revealed the SCU Director was never in the unit. Confidential interview with a fifth staff member revealed the SCU Director was always in the Administrator's office and never in the SCU. Confidential interview with a resident revealed the SCU Director was hard to get up with and stayed "up front" on the AL side of the facility most of the time. Telephone interview with the facility's contracted primary care provider (PCP) on 09/25/19 at 9:19pm revealed: -There used to be a RCC at the facility that followed up on all the orders and referrals. -The staff changed so frequently, the PCP now scheduled her own referral appointments and gave a note with the appointment information to the transportation staff. -She thought medication aides took care of the orders and the RCC oversaw the process. -There was no consistent staff to follow up with from one visit to the next at the facility. -She had to go back each visit to check and make sure things were done as ordered from the previous visit. -This had been ongoing for approximately two years. Interview with the SCU Director on 09/18/19 at 3:08pm revealed he had a dual role at the facility; he was the SCU Director and the Administrator's Assistant. Interview with the SCU Director on 09/18/19 at 5:07pm revealed: -He had been the SCU Director since approximately July 2019; there was no set date because it was a "blurred" transition from being	D 466		

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D 466	Continued From page 121	D 466		

the Business Office Manager (BOM)/Administrator's Assistant.
-He was responsible for monitoring of all staff and making sure paperwork on the SCU was complete.
-Paperwork included FL2s, care plans and "so on."
-The medications aides (MAs) were responsible for PCP orders; he checked behind the MAs.
-When the PCP came to the facility he checked for any changes in orders.
-There was a "pending" book kept in the medication room that he checked daily for any correspondence between the PCP and the facility to make sure all orders were carried out.
-He went to the SCU several times a day to check on staff and residents.
-He and the Administrator did daily walk throughs of the SCU prior to July 2019; since then he had done monthly walk throughs due to the facility being short staffed.

Interview with the SCU Director on 09/24/19 at 10:05am revealed:
-He spent most of his time as the Administrator's Assistant in offices on the assisted living (AL) side.
-He had an office on the SCU, but it was mostly used for storage.
-There had not been a RCC since sometime between April and July 2019.

Interview with the Administrator on 09/24/19 at 2:36pm revealed:
-The SCU Director was not often in the role of SCU Director.
-Everything shifted when the corporate office terminated the previous RCC who covered both the RCC role and the SCU Director role.
-The current SCU Director took over covering

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D 466	Continued From page 122 both roles as well. [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care & Supervision]. [Refer to Tag 270 10A NCAC 13F .0901(a) Personal Care & Supervision]. [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care]. The facility failed to assure a special care unit (SCU) coordinator was in the SCU eight hours a day, five days a week. The facility's failure to assure there was a SCU coordinator resulted in unsupervised staff and lack of coordination and follow up for the needs of residents on the SCU which was detrimental to the health, safety and welfare of residents on the SCU and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 10, 2019.	D 466		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 123	D912		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to housekeeping and furnishings, tuberculosis testing, nutrition and food service, and special care unit staffing.

The findings are:

1. Based on observations, record reviews, and interviews, the facility failed to assure the facility was free of hazards as evidence by live roach activity in the kitchen, dining room and a shared residents bathroom; a helium cylinder, artificial decorative grass, sharpened coloring pencils, food and beverages left unsecured and accessible to residents on the Special Care Unit (SCU). [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping & Furnishings (Type B Violation)].

2. Based on interviews and record reviews, the facility failed to assure 4 of 6 sampled residents (#2, #3, #5 and #14) had completed tuberculosis testing upon admission according to control measures for the Commission for Health Services. [Refer to Tag 234 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Examination & Immunizations (Type B Violation)].

3. Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 resident

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D912	Continued From page 124 sampled, (#13) who was diagnosed with difficulty swallowing and had an order for honey thickened liquids and a pureed diet.[Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 4. Based on observations and interviews, the facility failed to assure there was a special care unit (SCU) coordinator on the SCU eight hours per day, five days a week leaving staff on the SCU unsupervised and lack of follow up on concerns and needs of the residents. [Refer to Tag 466 10A NCAC 13F .1308(b) Special Care Unit Staffing (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to personal care and supervision, health care, resident rights, special care unit staffing, and implementation. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure the personal care needs were provided according to the residents' needs and care plan for 2 of 7 sampled residents including toileting, repositioning every 1 to 2 hours, incontinence care (Resident #17) and	D914		

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D914	Continued From page 125	D914		

repositioning (Resident #11). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care & Supervision (Type B Violation)].

2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#2 and #3) according to the needs of the residents who demonstrated exit seeking (#3), left the Secure Care Unit (SCU) without knowledge of the staff and was found one half mile from the facility in need of emergency medical attention for dehydration and (#2) who exhibited aggressive behaviors toward other residents. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A2 Violation)].

3. Based on interviews and record reviews, the facility failed to contact the primary care provider (PCP) for 2 of 7 sampled residents related to a pressure ulcer on the resident's right hip (#9) and two pressure wounds on a resident's ankles (#11). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

4. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishings, tuberculosis tests, personal care, supervision, health care, nutrition and food service, controlled substances, health care personnel registry reporting and special care unit staffing. [Refer to Tag 980 GS131D-25 Implementation (Type A1 Violation)].

5. Based on observations, interviews and record reviews, the facility failed to assure 3 of 3 sampled residents were protected from harm and

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D914	Continued From page 126 injury from a male resident who had aggressive behaviors which resulted in Resident #9 being pushed out of her wheelchair and had to be transported to the emergency room for evaluation, Resident #18 had been bruised as a result of being hit and Resident #4 had been kicked out of her wheelchair. [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type B Violation)] 6. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of residents residing in the Special Care Unit (SCU) for 16 of 36 shifts sampled for 12 days in August and September 2019. [Refer to Tag 465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for housekeeping and furnishings, tuberculosis tests, personal care, supervision,	D980		

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D980	Continued From page 127 health care, nutrition and food service, controlled substances, health care personnel registry reporting and special care unit staffing. The findings are: Confidential interview with a staff revealed: -The facility had been short staffed since May 2019; the corporate office was aware and had not responded. -There had been multiple interim Administrators at the facility for years with no consistent management. -The Administrator and SCU Director frequently worked on the floor to cover short shifts and as a result their time in the facility to oversee and manage other duties was reduced. Confidential interview with a second staff revealed: -The Administrator was "hardly here" at the facility and lately the Administrator was not at the facility at all. -There was not enough staff to take care of the residents at the facility. -When issues were told to the Administrator, nothing was done. Confidential interview with a third staff revealed the Administrator was at the facility approximately 2 times per week from 8:00am to 5:00pm. Confidential interview with a fourth staff revealed when there were resident or staffing concerns the staff member could not reach the Administrator when she was on call. Interview with the SCU Director on 09/17/19 at 8:54am revealed the Administrator was not working at the facility on 09/17/19.	D980		

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D980	Continued From page 128 Interview with the SCU Director on 09/18/19 at 3:08pm revealed: -He had a dual role at the facility; he was the SCU Director and the Administrator's Assistant. -He was responsible for supervising all the staff. -The facility had been short staffed and management staff had been covering some shifts as direct care staff. -The management team consisted of the Administrator, himself, the Activities Director, Maintenance Director and Kitchen Manager. -There had not been anyone from the corporate office or sister facilities to support the management team prior to 09/17/19. Telephone interview with the Activity Director (AD) on 09/22/19 at 6:52pm revealed: -She was working as the only medication aide in the building for second shift on 09/22/19. -The second MA left saying the SCU Director was coming in to work second shift on 09/22/19. -She contacted the SCU Director who said he was not able to come in. -She tried to contact the Administrator but she had not answered the phone nor responded to text messages. Interview with the SCU Director on 09/24/19 at 10:05am revealed: -The Administrator was not working on 09/24/19 and he did not think the Administrator was returning to work at the facility. -The Administrator had left her facility keys and facility cellular phone on the desk in the office. -He did not know if the Administrator had told anyone she would not be coming in and/or coming back. Telephone interview with the Chief Operations	D980		

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D980	Continued From page 129 Officer (COO) on 09/24/19 at 11:42am revealed: -The Administrator was on her way to the facility this morning (09/24/19). -Personal care aides (PCAs) were expected to report to the medication aides (MAs). -MAs reported to the SCU Director and the SCU Director reported to the Administrator. -Management members were responsible for supervising and redirecting staff. Interview with the Administrator on 09/24/19 at 2:36pm revealed: -She was at an appointment this morning (09/24/19) which she had not communicated to the SCU Director. -She had rushed out the evening before (09/23/19) leaving her keys and phone accidentally. -She had started a new job two weeks ago but it did not interfere with her responsibilities at the facility because she was available by phone. -She did not initially answer the AD's call on 09/22/19 because the AD called from her personal phone. -She spoke with the AD the evening of 09/22/19. -If she was not available for urgent situations, the SCU Director was close by the facility and could respond. -She had a job to do herself and relied on her management staff (Activity Director, SCU Director, Transportation staff and the Dietary Manager) and MAs/Supervisors to monitor staffs' job performance. -Management staff and MAs/Supervisor did not always monitor staff, but she did expect them to assist. Interview with an Executive Director (ED) from a sister facility on 09/25/19 at 10:00am revealed: -The Administrator was not coming into work at	D980		

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D980	Continued From page 130 the facility on 09/25/19. -She was expecting the SCU Director later in the day on 09/25/19. -She was there to cover until the Management Liaison arrived on 09/25/19. Interview with the Management Liaison on 09/25/19 at 3:01pm revealed: -The COO was responsible for supervising the Administrator. -She was a support for facility EDs. -She did not exactly know when someone from the corporate office was at the facility. -The corporate Quality Assurance person usually visited the facility quarterly and as needed. Noncompliance was identified in the following rule areas at violation level: 1. Based on interviews and record reviews, the facility failed to contact the primary care provider (PCP) for 2 of 7 sampled residents related to a pressure ulcer on the resident's right hip (#9) and two pressure wounds on a resident's ankles (#11). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#2 and #3) according to the needs of the residents who demonstrated exit seeking (#3), left the Secure Care Unit (SCU) without knowledge of the staff and was found one half mile from the facility in need of emergency medical attention for dehydration and (#2) who exhibited aggressive behaviors toward other residents. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A2 Violation)].	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL058010	A. BUILDING: _____ B. WING _____	R 09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE INN RETIREMENT COMMUNITY	826 EAST BOULEVARD HWY 17 N BYPASS WILLIAMSTON, NC 27892

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D980	Continued From page 131 3. Based on observations, interviews and record reviews, the facility failed to assure the personal care needs were provided according to the residents' needs and care plan for 2 of 7 sampled residents including toileting, repositioning every 1 to 2 hours, incontinence care (Resident #17) and repositioning (Resident #11). [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care & Supervision (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of residents residing in the Special Care Unit (SCU) for 16 of 36 shifts sampled for 12 days in August and September 2019. [Refer to Tag 465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)]. 5. Based on observations, interviews and record reviews, the facility failed to assure 3 of 3 sampled residents were protected from harm and injury from a male resident who had aggressive behaviors which resulted in Resident #9 being pushed out of her wheelchair and had to be transported to the emergency room for evaluation, Resident #18 had been bruised as a result of being hit and Resident #4 had been kicked out of her wheelchair. [Refer to Tag 338 10A NCAC 13F .0909 Residents' Rights (Type B Violation)]. 6. Based on observations, record reviews, and interviews, the facility failed to assure the facility was free of hazards as evidence by live roach activity in the kitchen, dining room and a shared residents bathroom; a helium cylinder, artificial decorative grass, sharpened coloring pencils, food and beverages left unsecured and accessible to residents on the Special Care Unit	D980		

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D980	Continued From page 132 (SCU). [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping & Furnishings (Type B Violation)]. 7. Based on interviews and record reviews, the facility failed to assure 4 of 6 sampled residents (#2, #3, #5 and #14) had completed tuberculosis testing upon admission according to control measures for the Commission for Health Services. [Refer to Tag 234 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Examination & Immunizations (Type B Violation)]. 8. Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 1 resident sampled, (#13) who was diagnosed with difficulty swallowing and had an order for honey thickened liquids and a pureed diet.[Refer to Tag 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)]. 10. Based on observations and interviews, the facility failed to assure there was a special care unit (SCU) coordinator on the SCU eight hours per day, five days a week leaving staff on the SCU unsupervised and lack of follow up on concerns and needs of the residents. [Refer to Tag 466 10A NCAC 13F .1308(b) Special Care Unit Staffing (Type B Violation)]. _____ The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing personal care, supervision, health care, residents' rights and special care unit staffing. The Administrator's failure to implement rules and regulations resulted in staff shortages of 0.75 to 10.81 hours for 16 shifts on the special care unit resulting in a lack of personal care	D980		

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D980	Continued From page 133 assistance with toileting, incontinence care and repositioning with residents developing pressure ulcers which were not reported to the primary care provider until the wounds were stage III; and a resident eloping from the facility and requiring emergency room treatment. The Administrator's failure to implement rules and regulations resulted in serious neglect and physical harm to residents and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/25/19 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 26, 2019.	D980		