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D 000	Initial Comments The Adult Care Licensure Section and the Perquimans County Department of Social Services conducted an annual survey and complaint investigation on March 5, 2020 through March 6, 2020 and March 10, 2020 through March 11, 2020. The complaint investigation was initiated by the Perquimans County Department of Social Services on January 23, 2020 and February 28, 2020.	D 000		
D 108	10A NCAC 13F .0311(b)(2) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. (2) Unvented fuel burning room heaters and portable electric heaters are prohibited. This rule apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the use of portable electric heaters were used in two resident bedrooms (#13, #14) of the facility. The findings are: Observation of resident room #14 on 03/05/20 at 9:40am revealed: -There was a resident asleep in the bed. -There was a portable electric heater sitting on the floor near the end of the bed and plugged into an electrical outlet in the wall next to the bed. -There was warm air blowing from the portable electric heater.	D 108		

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D 108	Continued From page 1 Observation of resident room #13 on 03/05/20 at 9:44am revealed: -There was a resident sitting on the side of the bed. -There was a portable electric heater sitting on the floor to the right of the bed and near the entrance to the room. -The portable electric heater was plugged into an electrical outlet in the wall. -There was warm air blowing from the portable electric heater. Interview with the resident in room #13 on 03/05/20 at 9:44am revealed: -He had the portable electric heater in his room for "about two weeks". -A staff member had put the portable electric heater in his room because that room was "so cold" when the weather was cold outside. -The weather was warm today. Observation of resident room #14 on 03/05/20 at 10:25am revealed: -There was a resident lying in bed asleep. -There was a black portable electric heater sitting on the floor midway the foot of the bed and entrance to the room. -The portable electric heater was plugged into an electrical outlet in the wall and there was warm air blowing from the portable electric heater. Interview with the resident in room #14 on 03/05/20 at 11:50am revealed: -The portable heater had been in his room since he was admitted to the facility about three weeks ago. -He felt the temperature in his room drop when the weather was cold outside. -The portable heater helped to keep him warm.	D 108		

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D 108	Continued From page 2 Interview with a personal care aide (PCA) on 03/05/20 at 11:30am revealed: -Rooms #13 and #14 "get really cold" and were the only two rooms that got cold. -She had seen the portable electric heaters in rooms #13 and #14. -She did not know who put the heaters in the rooms. Interview with a second PCA on 03/05/20 at 11:33am revealed: -The portable electric heaters had been in resident bedrooms #13 and #14 for a "couple weeks maybe one month". -She did not know anything else about the portable electric heaters. Interview with the Facility Manager on 03/05/2020 at 11:37am revealed: -The temperature had dropped inside the facility last week to below 70 degrees Fahrenheit (F) on the left hall. -She forgot the heaters were in the resident bedrooms. -The portable electric heaters were placed in rooms #13 and #14 on 02/27/20. -She called the Administrator on Thursday (02/27/20) and the Administrator "okayed" the use of the portable electric heaters in the bedrooms. -The "two end bedrooms were the coldest rooms". -The maintenance staff bought the portable electric heaters. -It had not been two weeks to a month that the portable electric heaters had been in the resident bedrooms. Observations of resident bedrooms #13 and #14 on 03/05/20 at 12:40pm revealed there were no	D 108		

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D 108	Continued From page 3 portable electric heaters in the room. Interview with the Administrator on 03/05/20 at 12:45pm revealed: -The facility "end room always get cold". -She kept portable electric heaters in storage and had been doing that since December. -There had been some cold nights. -She did not know until this morning (03/05/20) that the portable electric heaters had not been removed from the resident rooms. -The portable electric heaters had been in the resident rooms since 02/21/20 but should not have been plugged in. -The facility heating unit required maintenance in January 2020. Observation of the facility thermostats in the hallway on 03/05/20 at 9:00am revealed the thermostats were set at 79 degrees Fahrenheit (F) and the temperatures inside registered at 79 degrees F. Observation of the facility thermostats in the hallway on 03/06/20 at 7:25am revealed the thermostats was set at 79 degrees F and the temperatures registered at 77 degrees F and 79 degrees F.	D 108		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility neglected to respond immediately according to facility's policies for 1 of 1 sampled resident (#2) after the resident was found unresponsive and required cardiopulmonary resuscitation (CPR) and contacted emergency medical services (EMS).

The findings are:

Review of the facility's CPR policy and procedure revealed:
-The first staff member on the scene assumes control of the facility's response.
-Check the scene to make sure it is safe to proceed.
-If it appears safe, approach the victim and gently shake them while asking, "Are you all right?'
-If the victim does not respond call for help.
-If you are alone with an adult, call for help first, then start CPR if needed.
-Dial 911 immediately.
-All residents are a full code unless the residents had a Do Not Resuscitate (DNR) order or is under hospice care.

Review of Resident #2's FL-2 dated 07/31/19 revealed:
-Diagnoses included fetal alcohol syndrome and schizophrenia.
-There was documentation the resident was ambulatory.

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-The resident's recommended level of care was domiciliary.

Review of a county EMS patient care summary dated 01/18/20 revealed:
-An emergency call was received from staff at the facility at 7:21am that Resident #2 was found not breathing, face down in her bed by staff at 7:07am
-Staff initiated CPR.
-The staff reported Resident #2 had changed colors (referring to skin color, but the color was not specified).
-Resident #2 was found lying in her bed positioned half on her side and half on her back against the wall upon EMS arrival at the facility at 7:28am.
-Upon EMS arrival, staff had stopped performing CPR on Resident #2.
-Both of Resident #2's arms were contracted; there was no audible breath lung sounds or palpable carotid pulse.
-Resident #2's mouth was slightly open with her jaw clinched and fixed, and her tongue was swollen and purple.
-Both pupils were fixed and dilated, and it was documented Resident #2 was in rigor mortis (Rigor mortis is the stiffening of the muscles that begins to occur between two and six hours following death with rigor mortis beginning in the eyelids, neck, and jaw. Rigor mortis then spreads to the other muscles of the body within the next four to six hours).
-Resident #2 was connected to a cardiac monitor by EMS, but there was no detectable heart rate.
-Time of death was noted as 7:31am.
-The staff reported Resident #2 was last seen by third staff at 4:30am when Resident #2 asked to be repositioned on her side in bed.
-The morning staff reported when they went to do

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bed checks on the morning of 01/18/20 that they found Resident #2 face down in her bed and the staff could not wake her.

Telephone interview with an EMS staff on 02/24/20 at 2:57pm revealed:
-When EMS arrived at the facility on the morning of 01/18/20, Resident #2's upper extremities were drawn up and fixated and her face had been pushed to the side.
-Resident #2's tongue was swollen and sticking out, but it was not out of her mouth.
-The top of Resident #2's body was cold and stiff, but the bottom half of her body was still slightly warm.

Interview with the third shift personal care aide (PCA) on 03/06/20 at 9:15am revealed:
-She was the PCA who worked the 11pm -7am shift on the night of 01/17/20 going into the morning of 01/18/20.
-She was the only staff in the facility during the shift.
-She went in to Resident #2's room and checked on her about every hour or hour and half.
-She wrapped Resident #2 up in her bed covers at about 12:00am and placed her desk bell on her chest so Resident #2 could call for help if she needed assistance.
-When she was doing her rounds at approximately 4:00am, she went in to Resident #2's room and Resident #2 was awake.
-She asked Resident #2 if she was ok, rubbed Resident #2's forehead, and Resident #2 nodded her head.
-She repositioned Resident #2 to her right side and she "seemed fine".
-She checked on Resident #2 again at 5:30am and Resident #2 was still on her right side when she laid her hand on Resident #2's shoulder.

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-She rolled Resident #2 over in the bed and she "could not find any air" "(Resident #2) was not breathing)".
-She screamed for help and she started performing CPR on Resident #2.
-The first shift medication aide (MA) came inside Resident #2's room and started doing CPR on Resident #2 and called the facility manager.
-She could not remember when the MA came inside Resident #2's room and took CPR.
-She thought the MA called 911 but was not sure when the call was placed.
-She and the MA alternated performing CPR on Resident #2 for about forty-five minutes to an hour before EMS arrived.
-She could not remember if they performed one person or two person CPR prior to EMS arrival.
-She was supposed to get off at 6:00am on 01/18/20 so she "guessed it was about 5:30am" when the MA came to the facility.

Second interview with the same 11pm -7am PCA on 03/06/20 at 1:25pm revealed:
-She checked Resident #2 at 4:00am on 01/18/20 and repositioned her on her side so she was facing the wall because that was how Resident #2 wanted to be positioned.
-Resident #2 was still in the same position when she returned at 5:30am, but "she was already gone (dead)".
-She did a sternal chest rub to Resident #2's chest and listened for her heart beats and breathing.
-Resident #2 "looked at peace, her eyes were still open, had normal skin color, and her face felt warm".
-Resident #2's body texture felt soft and "she did not look like she had passed away, she looked peaceful".
-She grabbed Resident #2 and said, "you can't do

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this to me".
-She started doing chest compressions for CPR and there was no other staff who saw her doing CPR at first on Resident #2.
-She did not call for help before she started CPR because she did not have her personal cell phone and the facility phone was in the front office.
-She knew she needed to call for help, but she did not have any way to call.
-She yelled out and the MA "just happened to be coming inside" the facility and came and helped with CPR on Resident #2.
-She checked Resident #2 about four or five times between the hours of 11:00pm and 5:30am.

Interview with the MA on 03/06/20 at 12:27pm revealed:
-She was the MA who worked the 7am - 3pm shift on 01/18/20.
-She arrived at the facility between 6:45am and 6:50am on 01/18/20 and the PCA, who worked the third shift, was standing at the front door and left the facility as soon she arrived.
-The night shift PCA did not report any problems with any of the residents.
-She did not assist the third shift PCA with performing CPR on Resident #2.
-Another PCA on the first shift found Resident #2 unresponsive at the beginning of shift on 01/18/20 and they called 911 between 7:07am - 7:10am.
-The third shift PCA had already left the building.
-When they found Resident #2 on the morning of 01/18/20, she was face down in her bed; she was not breathing; she was already stiff; and her arms were folded back toward her upper body.
-Resident #2's mouth was partially open and the skin around her mouth was purplish in color.
-Resident #2's eyes were open, and the iris parts of her eyes were cloudy.

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-The staff performed CPR until EMS arrived.
-The night shift PCA did not assist with performing CPR for Resident #2 with the morning staff on 01/18/20.

Interview with a PCA on 03/06/20 at 11:06am revealed:
-She worked the first shift on 01/18/20 and the PCA who worked the third shift was standing by the front door of the facility when she arrived before the beginning of the first shift and the third shift PCA left shortly after she arrived.
-She did not do rounds with the third shift PCA and she found Resident #2 unresponsive at 7:07am when she went to wake up Resident #2.
-Resident #2 was lying face down in her bed and was cold to touch.
-She called for the MA to call 911 and started performing CPR on Resident #2.
-Both of Resident #2's arms were stiff and contracted around the area of her chest so it was hard trying to do CPR on the resident.
-The third shift staff had already left the building when EMS arrived (time not specified)

Interview with the Facility Manager on 03/06/20 at 10:25am revealed:
-She got a phone call from staff at the facility on 01/18/20 at approximately 7:07am that they had called 911 because they found Resident #2 unresponsive in bed.
-She arrived at the facility the same time as EMS arrived (time not specified).
-The PCA who worked the third shift was not in Resident #2's room or in the facility.
-She called the PCA who worked the third shift between 7:20 and 7:25am for her to come back to the facility so she could find out what happened to Resident #2.
-She did not see the third shift PCA perform CPR

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on Resident #2.
-It was the facility's policy that if staff was alone with a resident who needed CPR, staff was supposed to call for help and start CPR.

Interviews with the Administrator on 03/06/20 at 12:53pm and 1:00pm revealed:
-She only knew what she read from the investigative reports done by the facility manager after Resident #2 died.
-The first shift staff found Resident #2 "had passed away" around 7:07am, called 911 on 01/18/20 and the Manager and EMS arrived at the facility at approximately the same time.
-The EMS team took over resuscitation efforts from the facility staff.
-She had not talked with any staff specifically about what happened regarding the morning Resident #2 died.
-She believed the staff did everything that should have been done for Resident #2 when they found her unresponsive.
-She was not aware Resident #2 "was found stiff" when the first shift found her unresponsive on 01/18/20.

Review of a facility employee consultation form for the third shift PCA who worked 01/17/20 dated 03/07/20 revealed:
-The third shift PCA was asked by the manager to write a statement of what happened, (referring to Resident #2 on the morning on 01/18/20) but the PCA refused until she talked to the manager.
-The PCA proceeded to tell the manager how when she found Resident #2 that she started performing chest compressions.
-The Facility Manager called the Administrator.
-The PCA told the Administrator that she had not been totally honest about the death of a resident (Resident #2).

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-The PCA had found the resident (Resident #2) expired at 5:00am (01/18/20) and never reported to anyone.
-The PCA waited for the oncoming shift to find her (Resident #2).
-The PCA did not call EMS.

Review of a 24-Hour Initial HCPR Report dated 03/09/20 revealed:
-The Administrator documented the third shift PCA for 01/17/20 admitted that PCA found Resident #2 expired at 5:00am on 01/18/20.
-The third shift PCA did not report to anyone when she found Resident #2 expired.
-The PCA waited for the oncoming first shift supervisor to come in.
-The PCA "didn't say a word and walked out the door" of the facility.

Second interview with the Administrator on 03/10/20 at 8:50am revealed:
-She had conducted another interview with staff on 03/06/20.
-She had "one staff who was wishy washy about her statements" and it was the PCA who worked the third shift the night Resident #2 died.
-The third shift PCA initially reported to the Administrator that she last saw Resident #2 alive on 01/18/20 at 4:00am for rounds but the staff's statement of events kept changing with further questioning.
-When she first interviewed the third shift PCA on 03/07/20, the PCA said she found Resident #2 on the morning rounds and started chest compressions; that she tried to save Resident #2, but Resident #2 was already dead.
-Then the third shift PCA said she felt like she needed to tell the truth.
-The third shift PCA said she found Resident #2 dead when she did her rounds at 5:00am on

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01/18/20, but she did not do anything or call for EMS for Resident #2.
-The third shift PCA reported that she was scared when she found Resident #2 dead.
-The PCA waited for the first shift to arrive at the facility and she left the facility without notifying the incoming shift Resident #2 was already dead.
-The third shift PCA reported that she started the compressions on Resident #2 because she was trying to protect the next shift when they found Resident #2 dead.
-The Administrator believed the third PCA had gotten scared when she found Resident #2 was dead at 5:00am on 01/18/20.
-The third shift PCA should have called for help and initiated CPR when she found the resident.
-She had suspended the PCA effective 03/07/20 and reported the incident to the HCPR on 03/09/20.

Telephone interview with the third shift PCA on 03/10/20 at 12:27pm revealed:
-Resident #2 was alive when she last saw the resident between 5:00am to 5:30am on 01/18/20 when Resident #2 rang her desk bell.
-She went in Resident #2's room and provided incontinence care and positioned Resident #2 on her side with her back toward her room door.
-She placed a rolled throw behind Resident #2's back to prevent her from rolling back.
-She then did the other cleaning tasks that needed to be done in the facility.
-The three first shift staff came in about 6:45am and she left the facility.
-She was not sure exactly when she left the facility, but she guessed it was between 7:10am and 7:15am.
-She was not there when the 7am-3pm shift found Resident #2 or when EMS was called.

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D 271	Continued From page 13 The facility failed to ensure the continuation of CPR and emergency medical services were contacted immediately in accordance with the facility's policy when Resident #2 was found unresponsive and not breathing. The facility failed to respond to the emergency needs of Resident #2 resulting in neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/06/20 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 15, 2020.	D 271		
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 A2 VIOLATION Based on interviews and record reviews, the facility failed to notify the primary care provider for 1 of 3 sampled residents (Resident #2) who had significant changes in the ability to perform activities of daily living who required increased assistance by staff for ambulation, bathing, dressing, and grooming. The findings are: Review of Resident #2's FL-2 dated 07/31/19 revealed:	D 273		

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-Diagnoses included fetal alcohol syndrome and schizophrenia.
-There was documentation the resident was ambulatory.

Review of Resident #2's previous care plan dated 07/31/19 revealed:
-Resident #2 had no problems with ambulation and had limited upper extremity strength.
-Resident #2 was oriented and had adequate memory.
-Resident #2 was independent with eating and required supervision for toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #2's care plan dated 01/13/20 revealed:
-Resident #2 ambulated with a walker and had limited upper extremity strength.
-Resident #2 was oriented and had adequate memory.
-Resident #2 was required extensive assistance for eating and was totally dependent for toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of a county issued death certificate revealed Resident #2 died on 01/18/20.

Interview with a personal care aide on 03/06/20 at 11:06am revealed:
-Resident #2 was active and basically independent with all activities of daily living until the last 2 or 3 weeks before she died.
-Prior to the last 2 or 3 weeks, staff only had to assist Resident #2 with tying her shoes, zipping her coat, and supervised her during bathing and showers.
-In the last 2 or 3 weeks before Resident #2 died, Resident #2 became less active and was not

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D 273	Continued From page 15	D 273		

walking down to the dining room for meals.
-Resident #2 had started using a walker and sometimes had to use a wheelchair if she was too weak.
-Staff had to help Resident #2 get dressed.
-She did not report how Resident #2 had changed, but she did not have to because all of the staff saw Resident #2 needed more help.
-The Facility Manager told staff Resident #2 needed more assistance with her personal around the end of December 2019 or the beginning of January 2020.
-She just did what needed to be done to help Resident #2.

Interview with a medication aide on 03/06/20 at 12:27pm revealed:
-Resident #2 was basically independent until about the end of December 2019.
-Resident #2's health started to deteriorate then and she started using a walker and wheelchair.
-Resident #2 became less mobile and the PCAs had to help Resident #2 with bathing and dressing.
-Staff kept Resident #2 where they could see her in the common areas so they could check on the resident more frequently.
-She told the Facility Manager that Resident #2 had become more dependent upon the PCAs for her bathing, dressing, toileting needs at the end of December 2019.
-The Facility Manager verbally told the staff about how to address Resident #2's changes in care and to monitor Resident #2.
-The Facility Manager also asked staff to let her know of any changes in Resident #2's condition.
-The staff notified the Facility Manager when Resident #2 had a loss of appetite and was unable to void on 01/14/20.
-The Facility Manager was responsible to notify

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Resident #2's primary care provider (PCP) about the changes in her condition.
-The Facility Manager arranged for Resident #2 to be seen by her PCP on 01/14/20.

Telephone interview with the nurse at Resident #2's PCP on 03/09/20 at 2:00pm revealed:
-They last saw Resident #2 on 01/14/20 and their office was "shocked" at the condition of Resident #2.
-Resident #2 presented to their office on that day in a wheelchair.
-They sent Resident #2 to the emergency room because their office was not able to get a urine sample to check Resident #2 for a suspected urinary tract infection since the resident was not able to void.
-The PCP signed on Resident #2's care plan on 01/13/20, he did not realize the changes that had occurred with Resident #2 needing a walker for ambulation or that Resident #2 was totally dependent for all activities of daily living except eating.
-No one from the facility had notified their office of the changes in Resident #2's condition prior to 01/14/20 and the PCP had not noticed the changes indicated on the care plan.
-The PCP would have liked for the facility to have notified him in addition to sending the care plan of the changes in Resident #2's overall status.

Interview with the Facility Manager on 03/06/20 at 10:25am revealed:
-She noticed a change in Resident #2's overall status about 2 or 3 weeks before Resident #2 died.
-Resident #2 had become increasingly sluggish and less active.
-Resident #2 became dependent on staff to help with dressing, bathing, grooming, and she

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D 273	Continued From page 17 sometimes used a walker for mobility assistance. -She was responsible to update the residents' care plans when she noticed such changes in their care status. -She reassessed Resident #2's care plan for significant change and faxed the updated care plan to the PCP's office on 01/09/20. -She never called the PCP about the changes she saw in Resident #2's status. -She believed when she faxed the updated care plan to the PCP's office on 01/09/20 that it was the facility's notification to the PCP about the changes in Resident #2's care. Interview with the Administrator on 03/11/20 at 1:30pm revealed she expected the Facility Manager to have made telephone contact with Resident #2's PCP regarding the changes in Resident #2's activities of daily living and overall status. _____ The facility failed to notify the primary care provider for 1 of 3 sampled residents (#2) who had significant changes in health; had became totally dependent for her activities of daily living; and required staff assistance for bathing, dressing, bathing, grooming, and required the use the walker and sometimes used a wheelchair for ambulation. This failure of the facility to notify the primary care provider of the significant changes in Resident #2's condition resulted in substantial risk of neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/24/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 15,	D 273		

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D 273	Continued From page 18 2020	D 273		
D 440	10A NCAC 13F .1207 Facilities To Report Resident Deaths 10A NCAC 13F .1207 Facilities To Report Resident Deaths For purposes of this Section, facilities licensed in accordance with G.S. 131D-2 shall report resident deaths to the Division of Facility Services. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report 1 of 1 sampled resident's (#2) death to the Department of Health and Human Services. The findings are: Review of Resident #2's current FL-2 dated 07/30/19 revealed diagnoses included fetal alcohol syndrome and schizophrenia. Review of the county emergency medical services (EMS) report dated 01/18/20 revealed: -EMS was dispatched to the local assisted living facility for a 32-year-old female not breathing at 7:07am. -Resident #2 was found lying in her bed positioned half on her side and half on her back against the wall upon EMS arrival at the facility (time not specified). -Both of Resident #2's arms were contracted; there was no audible breath lung sounds or	D 440		

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D 440	Continued From page 19 palpable carotid pulse. -Resident #2's mouth was slightly open with her jaw clinched and fixed, and her tongue was swollen and purple. -Both pupils were fixed and dilated, and it was documented Resident #2 was in rigor mortis. -Resident #2 was connected to a cardiac monitor by EMS, but there was no detectable heart rate. -Time of death was noted as 7:31am. Interview with the Facility Manager on 03/06/20 at 8:20am revealed: -She did not know a death report had to be sent to the Department of Health and Human Services (DHHS). -An incident report regarding the death was faxed to the county department of social Services (DSS) to inform them of the death. Interview with theAdministrator on 03/11/20 at 9:45am revealed: -She did not know a death report had to be sent to DHHS in a situation where a death was not expected. -An incident report regarding the death had been sent to the county DSS by the manager.	D 440		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	D 451		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to notify the county department of social services of incidents resulting in injury requiring medical treatment and referral to a local hospital for emergency medical evaluation for 2 of 4 sampled residents (#1, #2).

The findings are:

1. Review of Resident #1's current FL-2 dated 04/10/19 revealed diagnoses included aftercare in trauma, epilepsy, "paroxventric" tachycardia, and diabetes.

Review of an accident/incident report dated 02/11/20 for Resident #1 revealed:
-The staff heard the resident holler, went to the resident's room and Resident #1 was on the floor.
-The resident complained of pain in the right wrist.
-The resident was transported to a local hospital emergency room for evaluation by a facility staff.
-There were no fax confirmation sheets attached to the incident/accident report.

Review of a hospital emergency department after visit summary dated 02/11/20 for Resident #1 revealed:
-The resident was seen for accidental fall.
-The resident was diagnosed with right wrist closed fracture and acute right knee pain.

Review of a hospital emergency department after

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visit summary dated 10/09/19 for Resident #1 revealed:
-The resident was seen for accidental fall.
-The resident was diagnosed with acute right hip pain.

Observation of Resident #1 on 03/05/20 at 10:04am revealed:
-He was wearing a wrist brace on his right wrist.
-He was ambulating in the hall with a slow shuffling gait using a cane.

Interview with Resident #1 on 03/05/20 at 10:04am revealed:
-He fell off his bed onto the floor "about two weeks ago".
-He broke his wrist.
-He went to the hospital.
-He had stitches in his wrist.

Interview with a personal care aide (PCA) on 03/05/20 at 1:35pm revealed:
-Resident #1 tripped over a computer cord in his room about 2 - 3 weeks ago.
-The resident was getting out of bed when he tripped and fell.

Interview with the Administrator on 03/05/20 at 3:45pm revealed:
-She was not aware the county DSS had not been sent an accident/incident report when Resident #1 was seen at the hospital emergency room for evaluation.
-She had information on Resident #1 at home but could not remember which incidents the information was related to.
-She did not have any information for any February incidents.

Interview with the Facility Manager on 03/06/20 at

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10:50am revealed:
-She did not have a confirmation to verify the 02/11/20 incident/accident for Resident #1 had been faxed to the county DSS.
-She could not recall any other falls that Resident #1 had where the resident had to be sent to the hospital for evaluation.

Refer to interview with county Adult Home Specialist on 03/05/20 at 11:24am.

Refer to Interview with the Administrator on 03/05/20 at 3:45pm.

2. Review of Resident #2's current FL-2 dated 07/03/19 revealed:
-Diagnoses included schizophrenia and fetal alcohol syndrome.
-Resident #2 was ambulatory.

Review of the facility's accident/incident reports for Resident #2 revealed:
-There was documentation on 12/03/19 that staff Resident #2 found on the floor (place not specified) and Resident #2 was transported to the hospital per Resident #2's request.
-The report was faxed to Resident #2's primary care provider and signed by the facility Manager.
-There was no documentation of the injuries that required emergency attention on 12/01/19 or 01/02/20.
-There was no documentation the county department of social services (DSS) was notified of the incidents that occurred on 12/01/19, 12/03/19, or 01/02/20.

Review of an emergency room discharge summary dated 12/01/19 for Resident #2 revealed Resident #2's treatment diagnoses included low back sprain and contusions to the

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left wrist and bilateral hip contusions from a fall in the bathtub during the previous night.

Review of an emergency room discharge summary dated 12/03/19 for Resident #2 revealed Resident #2's treatment diagnoses included a sprain of the right foot, contusions to the right shoulder and right chest wall, and weakness without a specific cause as a result of a reported fall in the shower.

Review of an emergency room discharge summary dated 01/02/20 for Resident #2 revealed Resident #2's treatment diagnoses included contusion of the right knee as a result of an accidental fall from bed.

Interview with the Facility Manager on 03/06/20 at 10:50am revealed:
-She thought she had faxed the accident/incident reports to DSS for Resident #2.
-She initialed the back page of the accident/incident reports once she faxed the report to DSS.
-If her initials were not on the page then the report was not sent to DSS.
-She did not have any accident/incident reports for Resident #2 for 12/01/19 or 01/02/20 and she did not know why she did not complete the reports.

Refer to interview with county Adult Home Specialist on 03/05/20 at 11:24am.

Refer to Interview with the Administrator on 03/05/20 at 3:45pm.

_____

Interview with the county Adult Home Specialist on 03/05/20 at 11:24am revealed she had not received any incident/accident reports from the

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D 451	Continued From page 24 facility since June 2019. Interview with the Administrator on 03/05/20 at 3:45pm revealed: -Incident/accident reports were supposed to be sent to the county department of social services (DSS) by the facility Manager. -She was supposed to get a copy of the incident/accident reports for monitoring. -She monitored incident/accidents monthly. -She was not aware the county DSS had not been notified of accident/incidents when residents were seen at the hospital emergency room for evaluation. -If the Facility Manager had notified the county DSS by faxing the incident/accident report, there would be a copy of the faxed confirmation attached to the incident/accident report, or the manager would initial and document the date and time the incident/accident report was sent to the county DSS.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record 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 medication aide training and	D912		

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D912	Continued From page 25 competency. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 5 staff sampled (Staff A, B, and E) who administered medications had successfully passed the written medication aide exam within 60 days of completing their medication clinical skills competency validation [Refer to Tag D935 G.S. 131D-4.B(b) ACH Medication Aide Training and Competency (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 interviews and record reviews, the facility failed to ensure residents were free neglect as related to health care and personal care and supervision. The findings are: 1. Based on observations, interviews and record reviews, the facility neglected to respond immediately according to facility's policies for 1 of 1 sampled resident (#2) after the resident was found unresponsive and required cardiopulmonary resuscitation (CPR) and contacted emergency medical services (EMS). [Refer to Tag 271 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)].	D914		

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D914	Continued From page 26 2. Based on interviews and record reviews, the facility failed to notify the primary care provider for 1 of 3 sampled residents (Resident #2) who had significant changes in the ability to perform activities of daily living who required increased assistance by staff for ambulation, bathing, dressing, and grooming [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the	D935		

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D935	Continued From page 27 individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 5 staff sampled (Staff A, B, and E) who administered medications had successfully passed the written medication aide exam within 60 days of completing their medication clinical skills competency validation. The findings are: 1. Review of Staff A's personnel record, medication aide/personal care aide (MA/PCA), revealed:	D935		

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D935	Continued From page 28 -Staff A was hired on 07/15/19. -Staff A completed the state-approved 15-hour medication administration training and completed the medication clinical skills competency validation which was signed by a registered nurse both on 07/19/19 -Staff A had no documentation of successfully passing the written medication administration examination within 60 days of completing the medication clinical skills validation. Review of a resident's September 2019 medication administration record (MAR) revealed there was documentation Staff A administered medication on 09/21/19. Review of a resident's October 2019 MAR revealed there was documentation Staff A administered all medications on the 3-11 shift on 10/14/19; one medication on 10/15/19; and all medications on the 3-11 shift on 10/26/19. Review of a resident's November 2019 MAR revealed there was documentation Staff A administered medication on 11/26/19 and 11/28/19. Interview with the Facility Manager on 02/21/20 at 4:35 pm revealed: -Staff A was not allowed to administer medications due to not taking the written medication administration exam. -When PCAs worked alone on third shift, the PCA was supposed to contact the Facility Manager by telephone so she would come to the facility and administer any medications if needed. Interview with Staff A on 03/10/20 at 4:07pm revealed: -She was not sure when her first medication	D935		

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clinical skills competency validation checklist was completed, but she believed it was sometime around May 2019.
-The Facility Manager told her she needed to take the written medication administration exam.(time not specified), but she did not take it.
-Her medication clinical skills competency validation checklist was redone on 02/27/20.
-She was scheduled to take the written medication administration exam in April 2020.
-She thought she had passed medications to the residents in the facility in September 2019, October 2019, and November 2019.
-She stated, "no one at the facility" had told her she "could not pass medications".

Interview with the Facility Manager on 03/10/20 at 3:56 pm revealed:
-Staff A had worked at the facility for more than two months.
-She knew that MAs had to take the written medication administration exam within 60 days of having a nurse validate their medication clinical skills competency validation checklist or they could no longer administer medications.
-Staff A passing medications was "an oversight" as she had not kept up with when Staff A's 60 days would expire.

Interview with Administrator on 3/11/20 at 9:23am revealed she did not know Staff A continued administer medications after her 60 days had expired.

Refer to interview with the Administrator on 03/11/20 at 9:23am.

Refer to interview with the Administrator on 03/11/20 at 1:30pm.

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D935	Continued From page 30 2. Review of Staff B, personal care aide/dietary staff (PCA) personnel record revealed: -Staff B was hired on 08/22/18. -She had completed medication clinical skills competency validation checklists on 11/27/18 and 03/11/19. -She had completed the 15-hour state approved medication aide training on 11/27/18 and 03/11/19. -There was a signed medication aide job description dated 11/27/18. -A medication aide testing database search was completed for Staff B on 07/19/18 that resulted in no finding for Staff B. -There was no documentation Staff B had passed the written medication aide exam. Review of Resident #1's September 2019 - March 2020 medication administration records (MARs) revealed: -Staff B documented administration of medication at 8:00pm on 09/01/19, including a controlled substance, Ativan 1mg tablet (used to treat anxiety). -Staff B documented administration of medications at 8:00am on 10/26/19 and 11/16/19 including a controlled substance. -Staff B documented administration of medications at 8:00am and 11:30am on 12/07/19. Interview with Staff B on 03/06/20 at 9:17am revealed: -She worked as a PCA fill-in. -She worked all shifts when needed. -She was not a MA but was "working on it". Telephone interview with Staff B on 03/10/20 at 12:25pm revealed: -She had access to medications when she worked.	D935		

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-As a PCA, she could administer "over-the-counter" medications such as Tylenol, to the residents.

Interview with the Administrator on 03/10/20 at 4:35pm revealed:
-She was responsible to ensure staff qualifications were in personnel records but had delegated the responsibility to the facility Manager.
-She tried to get to the facility monthly to review personnel records.
-She had not looked at personnel records in a "couple of months" and probably had not been at the facility since January 2020.
-She thought another management staff had been to the facility in January 2020.

Interview with the Facility Manager on 03/10/20 at 5:20pm revealed:
-She tried to check personnel records every 2 - 3 months.
-She tried to select at least 2 - 3 personnel records every other month to make sure everything was in the personnel record, such as medication aide qualifications.

Interview with the Administrator on 03/10/20 at 5:50pm revealed she was not aware PCAs had access to keys to the medication cart.

Interview with a resident on 03/11/20 at 12:00pm revealed:
-Sometimes Staff B worked at night.
-Sometimes Staff B administered his medications.
-He did not know the last time Staff B had administered him medications.

Interview with the Facility Manager on 03/11/20 at

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D935	Continued From page 32 12:22pm revealed: -She had completed an audit of Staff B's personnel record on 11/19/20. -She identified and documented on the personnel record audit form on 11/19/19 that Staff B needed to take and pass the medication aide test. -Staff B should have not been administering medications after 60 days of the medication clinical skills evaluations and had not passed the medication aide test. -She "guess"[ed] it was her responsibility to make sure staff knew when their 60-day timeframe for passing the medication aide test was up. -It would be her responsibility to remove staff from the medication cart who were not qualified to administer medications. -She could see concerns with unqualified staff administering medications correctly. -She had never had an issue with medication errors. Refer to interview with the Administrator on 03/11/20 at 9:23am. Refer to interview with the Administrator on 03/11/20 at 1:30pm. 3. Review of Staff E's personnel record, medication aide/personal care aide (MA/PCA), revealed: -Staff E was hired on 12/03/18. -Staff E had completed the state-approved 15-hour medication administration training and completed the medication clinical skills competency validation and was signed by a registered nurse, both on 12/03/18. -Staff E had no documentation of successfully passing the written medication administration exam within 60 days of hire. -Staff E's personnel record was audited by	D935		

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administrative staff for medication aide qualifications on 02/27/19 and 04/29/19 and it was noted that Staff E "needed to pass the state medication aide test".

Review of the residents' March 2019 medication administration records (MARs) revealed there was documentation Staff E administered medications to residents on 03/15/19, 03/17/9, 03/23/19, 03/24/19, 03/27/19, and 03/29/19 at 8:00am and 03/12/19, 03/13/19, 03/14/19, 03/21/19, 03/22/19, 03/26/19, and 03/28/19 at 8:00pm.

Review of the residents' April 2019 MARs revealed Staff E administered medications to residents on 04/06/19 at 8:00am and 04/02/19, 04/03/19, 04/04/19, 04/08/19, 04/09/19, and 04/30/19 at 8:00pm.

Review of the residents' May 2019 MARs revealed there was documentation Staff E administered medications to residents on 05/04/19, 05/26/19, and 05/30/19 at 6:00am, 05/04/19, 05/26/19, and 05/28/19 at 8:00am, and 05/02/19, 05/06/19, 05/23/19, 05/28/19, and 05/29/19 at 8:00pm.

Review of the residents' June 2019 MARs revealed there was documentation that Staff E administered medications to residents on 06/01/19 at 6:00am, 06/01/19 and 06/24/19 at 8:00am, and 06/04/19 at 8:00pm.

Interview with a resident revealed Staff E administered medications to the resident, but the resident was not able to specify when was the last time Staff E administered medications to the resident.

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D935	Continued From page 34 Interview with Staff E on 03/11/20 at 10:46am revealed: -She was trained to be a MA, but she never took the test. -A nurse told her she could pass meds for a certain period of time (60-90 days), but she could not specify when that happened. -She last "passed medications around the end of 2019" at the facility. Interview with the Facility Manager on 03/11/20 at 12:21pm revealed: -Staff E was originally hired to be a MA in December 2018, but she did not pass the written medication aide exam (time not specified). -She did not know Staff E was still administering medications to the residents and she was beyond 60 days of hire. -It was her responsibility to make sure staff were aware they were near the end of the days for them to continue to work on the medication cart without passing the written medication aide exam. -The audit of Staff E's personnel record dated 02/27/19 was completed by another administrative assistant from another facility and Staff E should have been removed from the medication cart then. -She completed the audit of Staff E's personnel record dated 04/29/19 and she should have removed Staff E from the medication cart and stopped her from administering medications to the residents. -She "got busy and just forgot to do it". Refer to interview with the Administrator on 03/11/20 at 9:23am. Refer to second interview with the Administrator on 03/11/20 at 1:30pm.	D935		

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D935	Continued From page 35 Interview with Administrator on 3/11/20 at 9:23am revealed: -All staff must be checked off by the registered nurse and then would be trained for 3-5 days with the Facility Manager. -Staff must take the written medication administration exam within 60 days of completing Medication Clinical Skills Checklist or stop administering medications. Second interview with the Administrator on 03/11/20 at 1:30pm revealed: -The Facility Manager was responsible for making sure staff were qualified to administer medications at the facility. -The facility manager was responsible to make sure staff were removed from administering medications if they had not passed the written medication aide exam within 60 days of hire or completing their medication clinical skills checklists. -She did not know there were staff who were still administering medications who had not passed the written medication aide exam. _____ The facility failed to assure 3 of 5 staff had successfully passed the written state medication administration test within 60 days of completing their validation for medication clinical skills competency and continued to perform unsupervised medication aide duties. The failure resulting in placing residents at risk for medication errors and was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/11/20 for this violation.	D935		

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D935	Continued From page 36 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 25, 2020.	D935		