STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096009	A. BUILDING: _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODARD'S RETIREMENT VILLAGE	1019 ROYAL AVENUE GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a COVID-19 focused Infection Control survey and complaint investigation with an onsite visit on 09/24/20 and a desk review survey on 09/24/20 to 09/25/20 and 09/28/20 to 10/02/20 with a telephone exit date on 10/02/20.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 2 of 6 sampled staff (Staff B and Staff E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) in accordance with G.S. 131E-256 upon hire. The findings are: 1. Review of Staff B'S, Activity Director; Personal Care Aide; and Medication Aide, personnel record revealed: -Staff B was hired on 07/20/20. -There was no documentation of a HCPR check being completed upon hire. -There was documentation a HCPR check was completed on 09/10/20 with no substantiated findings. Telephone interview with the facility Manager on	D 137		

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D 137	Continued From page 1 10/02/20 at 1:56pm revealed: -She had written down in a notebook that she needed to complete Staff B's HCPR check. -She did not remember when she wrote down that she needed to complete the HCPR check for Staff B. -She reviewed that notebook on 09/10/20 and completed Staff B's HCPR check on 09/10/20 -She had been busy cooking and working as a supervisor at another (sister) facility prior to 09/10/20 and had been unable to complete Staff B's HCPR check. -She was responsible for completing HCPR checks prior to the new staff members start date. 2. Review of Staff E's, Personal Care Aide, personnel record revealed: -Staff E was hired on 08/24/20. -There was no documentation of a Health Care Personnel Registry (HCPR) check being completed upon hire. -There was documentation a HCPR check was completed on 09/10/20 with no substantiated findings. Telephone interview with the facility Manager on 10/02/20 at 1:56pm revealed: -She had written down in a notebook that she needed to complete Staff E's HCPR checks. -She did not remember when she wrote down that she needed to complete the HCPR check for Staff E. -She had reviewed that notebook on 09/10/20 and completed Staff E's HCPR check on 09/10/20 -She was responsible for completing HCPR checks prior to the new staff members start date.	D 137		

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D 139	Continued From page 2	D 139		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 6 sampled staff (Staff B) had a criminal background check completed upon hire. The findings are: Review of Staff B's, Activity Director; Personal Care Aide; and Medication Aide, personnel record revealed: -Staff B was hired on 07/20/20. -There was documentation of a statewide criminal background check completed on 09/10/20. Telephone interview with the facility Manager on 10/02/20 at 1:56pm revealed: -She was responsible for completing criminal background checks prior to Staff B's start date. -She had written down in a notebook that she needed to complete Staff B's criminal background check -She did not remember when she wrote down that she needed to complete Staff B's criminal background check. -She had reviewed that notebook on 09/10/20 and completed Staff B's criminal background check on 09/10/20 -She had been busy prior cooking and working as a supervisor at another (sister) facility to 09/10/20 and had been unable to complete Staff B's	D 139		

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D 139	Continued From page 3 criminal background check.	D 139		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of	D 255		

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care no longer matches what is needed;
(K) new onset of impaired decision-making;
(L) continence to incontinence or indwelling catheter; or
(M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure an assessment was completed within 10 days following a significant change for 2 of 4 sampled residents (#2, #4) with mobility status changes.

The findings are:

1. Review of Resident #4's current FL-2 dated 01/29/20 revealed:
-She had a diagnosis of Alzheimer's disease.
-She was constantly disoriented.
-She was incontinent of bladder and bowel.

Review of Resident #4's current care plan dated 09/23/20 revealed:
-Resident #4 required total assistance with bathing, dressing, and grooming.
-Resident #4 required extensive assistance with transfers and toileting.
-Resident #4 required limited assistance with ambulation.
-Resident #4 used a wheelchair.
-Resident #4 had significant memory loss and must be directed.

Review of Resident #4's previous care plan dated 07/10/20 revealed:
-Resident #4 required extensive assistance from staff with toileting. bathing, dressing, and

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grooming.
-Resident #4 required bowel and bladder training every 2 hours.
-Resident #4 required limited assistance with transfers and ambulation.

Observations of Resident #4 on 09/24/20 from 10:40am - 11:20am revealed:
-The resident was sitting in a wheelchair located in the Special Care Unit (SCU) living room.
-The foot pedals of the wheelchair where not flat but were raised.
-The resident was wearing socks and her feet were flat with her heels resting on the floor.
-The resident would intermittently rub her feet against each other and along the floor.

Telephone interview with a personal care aide (PCA) on 09/29/20 at 3:00pm revealed:
-Resident #4 had poor balance, an unsteady gait, and was in a wheelchair for about two months.
-Resident #4 had been in a wheelchair for about two months.

Telephone interview with a second PCA on 09/30/20 at 12:08pm revealed:
-Resident #4 was wheelchair dependent.
-Resident #4 would sit in the wheelchair with her feet propped on the foot pedals.

Telephone interview with a third PCA on 10/01/20 at 4:30pm revealed Resident #4 was wheelchair dependent.

Telephone interview with the family member of Resident #4 on 10/01/20 at 8:03am revealed:
-Resident #4 had become wheelchair dependent.
-Resident #4 had not been able to walk since 08/03/20.
-Resident #4 could walk with assistance with of

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staff.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 09/28/20 at 12:29pm revealed Resident #4 had a fall In June 2020 and had not been able to walk since that fall.

Attempted telephone interview with the facility's contracted Registered Nurse on 10/01/20 at 8:45am was unsuccessful.

Refer to the telephone interview with the Facility Manager on 09/29/20 at 11:11am.

2. Review of Resident #2's current FL-2 dated 11/06/19 revealed:
-Diagnoses included Alzheimer's disease, stroke, and chronic obstructive pulmonary disorder.
-The resident was ambulatory, intermittently disoriented and required staff assistance with bathing, feeding, and dressing.
-The resident was incontinent of bowel and bladder.

Review of Resident #2's current care plan dated 09/23/20 revealed:
-The resident required supervision with eating, ambulation, and transfers.
-The resident required extensive assistance with toileting, bathing, dressing, and grooming.
-The resident was sometimes disoriented, forgetful, needed reminders, and had limited ability sometimes with an unsteady gait.

Review of Resident #2's previous care plan dated 07/01/20 revealed:
-The resident required supervision with eating, ambulation, and transfers.
-The resident required extensive assistance with

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D 255	Continued From page 7 toileting, bathing, dressing, and grooming. Observation of Resident #2 on 09/24/20 at 10:40am revealed the resident was sitting in a wheelchair located in the television room of the Special Care Unit (SCU). Observation of Resident #2 on 09/24/20 at 12:30pm revealed the resident was sitting in a wheelchair located in the television room of the SCU pointing at and yelling for someone to remove another resident from the television room. Interview with a nursing assistant (NA) on 09/24/20 at 12:49pm revealed Resident #2 was confused, could not walk and depended on a wheelchair for mobility. Telephone interview with the medication aide/supervisor (MA/S) on 09/28/20 at 9:56am revealed: -Resident #2 was ambulatory when she was first admitted to the facility. -Resident #2 became wheelchair dependent in March 2020 because of a decrease in balance and ambulation. -Care plans were completed by the facilty's contracted Registered Nurse (RN) and the Business Office Manager (BOM). -When a resident had a change from ambulatory to non-ambulatory the change should be documented on the care plan. -Care plans were completed every 3 - 6 months. -She did not know a resident needed a new care plan when a significant change occurred. -It would be the responsibility of the MA/S to inform the facilty's contracted Primary Care Provider (PCP)and Facility Manager when a resident had a change in condition.	D 255		

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-The facility's contracted PCP and the Facility Manager were both informed of Resident #2's change in condition in March 2020.

Telephone interview with the Resident #2's primary care provider (PCP) on 09/28/20 at 12:00pm revealed:
-The Registered Nurse (RN) was responsible for completing all care plans.
-Resident #2 has been wheelchair dependent for about 6 months.
-She was not contacted by the facility regarding Resident #2's decrease in ambulation.
-She expected to have been contacted by the facilty regarding Resident #2's decrease in ambulation so the resident could be evaluated to determine the change in condition.

Telephone interview with the Facility Manager on 09/29/20 at 11:11am revealed:
-She knew Resident #2 was now using a wheelchair.
-She questioned staff as to why Resident #2 was in the wheelchair.
-She was told by staff Resident #2 could ambulate with staff holding the resident's hand but they preferred Resident #2 use a wheelchair for safety reasons.

Telephone interview with the NA on 09/29/20 at 3:00pm revealed:
-Resident #2 could not walk and could not stand independently.
-Resident #2 was ambulatory with staff holding the residents hand when she first arrived in October 2019.
-Resident #2 progressed to a wheelchair around January or February 2020.

Telephone interview with Resident #2's Power of

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D 255	Continued From page 9 Attorney (POA) on 09/30/20 at 2:37pm revealed: -The resident was ambulatory when first arrived to the facility October 2019. -The resident was in a wheelchair when she last saw the resident 09/23/20. -The resident had not walked in about 3 months. Attempted telephone interview with the facility's contracted Registered Nurse on 10/01/20 at 8:45am was unsuccessful. Refer to the telephone interview with the Facility Manager on 09/29/20 at 11:11am. _____ Telephone interview with the Facility Manager on 09/29/20 at 11:11am revealed: -The facility had a contracted Registered Nurse (RN) to complete care plans. -The RN would complete care plans every 3 months. -The RN would complete care plans sooner if the resident had a significant change such as a change in blood sugar, ambulation status , and/or mental status change. -She did not know the required timeframe to complete a significant change Care Plan. -The RN would have come to the facility as soon as she had been called. -The PCP had also completed care plans for residents. -When a resident had a change in condition the PCA/NAs were responsible for telling the MA/S.	D 255		
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	D 269		

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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.

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

Based on observations, interviews and record review, the facility failed to ensure foot care and repositioning was provided for 1 of 4 sampled residents (#4) resulting in unstageable pressure ulcers to both her left and right heels.

The findings are:

Review of Resident #4's current FL-2 dated 01/29/20 revealed:
-She had a diagnosis of Alzheimer's.
-She was constantly disoriented.
-She was incontinent of bladder and bowel.

Review of Resident #4's current care plan dated 09/23/20 revealed:
-Resident #4 required total assistance from staff with bathing, dressing, and grooming.
-Resident #4 required extensive assistance with transfers and toileting.
-Resident #4 required limited assistance with ambulation.
-Resident #4 required bowel and bladder training every 2 hours.
-Resident #4 required daily skin monitoring related to bowel and bladder training.
-Her skin was documented as frail.
-Resident #4 used a wheelchair.
-Resident #4 had significant memory loss and must be directed.

Review of Resident #4's previous care plan dated

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D 269	Continued From page 11 07/10/20 revealed: -Resident #4 required extensive assistance from staff with toileting. bathing, dressing, and grooming. -Resident #4 required bowel and bladder training every 2 hours. -Resident #4 required limited assistance with transfers and ambulation. Review of Resident #4's most current licensed health professional support (LHPS) evaluation dated 06/26/20 revealed: -Resident #4 required limited (supervision) to extensive assistance from staff with activities of daily living (ADLs). -Resident #4 required bowel and bladder training every two hours. -There was a recommendation to monitor the resident's skin daily related to incontinence. Review of a handwritten physician's order for Resident #4 dated 09/23/20 revealed: -There was an order for home health nursing evaluation for wound care. -Resident #4 had unstageable pressure ulcers to both her right and left heels. Observations of Resident #4 on 09/24/20 from 10:40am - 11:20am revealed: -The resident was sitting in a wheelchair located in the Special Care Unit (SCU) living room. -The foot pedals of the wheelchair were not flat, but were raised. -The resident was wearing socks and her feet were flat with her heels resting on the floor. -The resident would intermittently rub her feet against each other and along the floor. -Staff did not reposition the resident or relieve pressure from her feet and/or heels.	D 269		

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D 269	Continued From page 12 Virtual observation of Resident #4 on 09/30/20 at 10:10am revealed: -The resident was lying on her right side in bed. There was no padding at the pressure points between the resident's ankles and lower legs. -On the back of the resident's right heel was a dark plum to brown area approximately 2 inches long (") by 3" wide in diameter extending towards the inner aspect of the heel. The skin was dry, cracked, and intact. The area was sunken in deeper than the perimeter of skin around it. -On the resident's outer left heel was a dark plum to brown area approximately 3" in diameter from the mid back of the heel towards the outer aspect. The area was dry, cracked, and skin intact. -The resident did not move her feet away when PCA touched the heel wounds. Interview with the first medication aide/supervisor (MA/S) on 09/30/20 at 9:12am revealed: -A personal care aide (PCA) had told her on 09/23/20 that Resident #4 had blisters on the heels of her feet. -She had last checked Resident #4's feet on 09/23/20. -She did not know the last time prior to 09/23/20 that she had checked Resident #4's feet. -Resident #4 had what appeared to be blisters on the heels of both of her feet. -She put lotion on Resident #4's feet on 09/23/20. -She documented the state of Resident #4's heels on a note for Resident #4's Primary Care Provider (PCP) on 09/23/20. -Resident #4's PCP was scheduled to come to the facility on 09/23/20 and she gave the note about Resident #4's heels to Resident #4's PCP. -Resident #4's PCP ordered her legs to be elevated and monitored on 09/23/20, the order had been placed in Resident #4's record.	D 269		

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D 269	Continued From page 13 -She did not know what caused pressure ulcers. Telephone interview with a PCA on 09/29/20 at 3:00pm revealed: -Resident #4 had poor balance, an unsteady gait, and was in a wheelchair. -Resident #4 had been in a wheelchair for about 2 months. -Resident #4 would sit with her feet crossed and heels on the floor. -Resident #4 had pressure ulcers to both heels. -She noticed the wounds to Resident #4's heels about 1 week ago when she was changing the resident's socks. -Resident #4's heels were black, the skin was closed, and were not mushy when pressed. -She didn't think the heels were painful because Resident #4 would not withdraw her heels when they were palpated. Telephone interview with the second PCA on 09/30/20 at 12:08pm revealed: -The PCAs put lotion on Resident #4's feet daily. -Resident #4 was the only resident in the Special Care Unit that had sores on her feet. -She had not noticed the sores of Resident #4's heels prior to 09/23/20 until she was told about them by the MA/S. -She did not know why Resident #4's heels had sores on them. -Resident #4 was wheelchair dependent. -When Resident #4 sat in her wheelchair, her feet would be resting on the foot rests. -Resident #4 had on socks when the bottom of her feet had been resting on the foot rest of her wheelchair. -Sometimes Resident #4 would prop her feet on the floor when in the wheelchair. -She had tried to keep Resident #4's feet propped up on a pillow.	D 269		

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D 269	Continued From page 14 -She had not received an order to keep Resident #4's feet propped on a pillow. -She did not know how long she had been propping Resident #4's feet on a pillow. -She worked first shift, 7:00am to 3:00pm and when she would come in to work, Resident #4 was usually been in her bed. -It took two people to get Resident #4 out of bed and take her to the bathroom. -It took 30 minutes for Resident #4 to use the bathroom. -After staff assisted Resident #4 to the bathroom, the PCA's sat the resident in her wheelchair for breakfast. -After breakfast, staff got Resident #4 out of her wheelchair and walked her around the SCU for 30 minutes. -After the 30-minute walk, staff put Resident #4 back into her wheelchair in the television room because she would get off the couch. -After that, Resident #4 would be wheeled to the dining room by staff for lunch around 11:45am. -Resident #4 ate lunch for about one hour. -After lunch, the PCAs on duty would walk Resident #4 for 30-minutes around the SCU. -After the 30-minute walk, Resident #4 would be placed back into her wheelchair at 1:30pm. -At 2:15pm Resident #4 was walked around the SCU for another 30-minutes until 2:45pm. -At 2:45pm Resident #4 was placed back in her wheelchair. -After the last walk, the second shift PCAs took over care of the resident. -She walked Resident #4 on her shift whenever she was scheduled to work. -Resident #4 would always sleep on her right side. -Resident #4 could independently turn herself but would not. -Staff did not prompt Resident #4 to turn or	D 269		

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reposition and did not reposition the resident to turn every two hours when in bed or in the wheelchair.

Interview with a second PCA on 10/01/20 at 1:52pm revealed:
-She worked first shift, 7:00am to 3:00pm.
-Resident #4 would spend 3 hours of her 8-hour shift in her wheelchair with her socks on.
-Resident #4 would rub the heel of one of her feet against the other one when she she was in her bed.

Interview with a third PCA on 10/01/20 at 4:30pm revealed:
-She worked second shift, 3:00pm to 11:00pm.
-She provided foot care to Resident #4 on her bath days, Monday, Wednesday, Friday and Saturday.
-When she had provided foot care, she applied lotion to the resident's feet if they were dry.
-She did not document foot care.
-She had last checked Resident #4's feet on 09/20/20 and found Resident #4's feet were dry so she applied moisturizer.
-She had not noticed any skin breakdown with Resident #4's feet on 09/20/20.
-If she had noticed any breakdown, she would have reported it to the MA/S.
-When she came in for second shift, Resident #4 was usually in her room sitting in her wheelchair.
-At 4:30pm staff would assist Resident #4 to the bathroom for toileting which took about 15-minutes in the bathroom.
-At 5:00pm Resident #4 was taken to the dining room in her wheelchair for dinner.
-When Resident #4 had finished her dinner, staff took Resident #4 to the bathroom for toileting for 15-minutes.
-At about 5:45pm, Resident #4 would be wheeled

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back to her room and placed in her chair in her room.
-At about 7:45pm staff would take Resident #4 to the bathroom for toileting for 10-15 minutes.
-At 8:30pm when Resident #4 got sleepy, staff assisted her to bed for the night.
-She checked on Resident #4 every 2-hours until 11:00pm, to make sure she was still breathing and that her incontinent brief was dry.

Interview with the family member of Resident #4 on 10/01/20 at 8:03am revealed:
-She did not think staff provided foot care to Resident #4.
-She had been notified on 09/23/20 by Resident #4's PCP that she had unstageable foot ulcers.

Interview with the Branch Director/Registered Nurse of the local home health provider on 10/01/20 at 1:27pm revealed:
-Resident #4's last home health referral had been received on 07/03/20 for home health nursing for proper healing of a forehead wound, pressure ulcer prevention, and medication management.
-The home health nurse's last visit with Resident #4 had been on 08/25/20 from the 07/03/20 order.
-The home health nurse had taught the staff on duty in SCU how to do a complete and proper skin assessment for Resident #4 as apart of the order for pressure ulcer prevention.
-The home health nurse had taught the SCU staff about pressure release options that included different turning positions and taught the staff how to reposition Resident #4 every 2 hours unless otherwise ordered by a physician.
-The timeframe of the development of unstageable pressure ulcers depended upon the resident's nutritional status, circulation issues, and venous problems.

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D 269	Continued From page 17 -An example provided was compromised nutritional status could speed up the development of a pressure ulcer. -Resident #4's unstageable pressure ulcer could have been visible for 5 to 7 days before her PCP had been notified of the pressure ulcers. -The facility staff should have seen some sort of change in color and texture in Resident #4's heels prior to the unstageable ulcers. Interview with Resident #4's PCP on 10/01/20 at 9:28am revealed: -She had been notified by staff when she had gone to the facility on 09/23/20 that Resident #4 had sores on her feet. -She had expected to be notified immediately when staff had saw the wounds to Resident #4's heels. -A delay in care could cause Resident #4's unstageable pressure ulcers to become infected, the resident could become septic which would lead to death. -She had ordered home health nursing for wound care for the unstageable pressure ulcers to Resident #4's feet on 09/23/20. -Resident #4's pressure ulcers to her heels could happen in a few days due to Resident #4 poor nutrition or the resident rubbing her feet together constantly. -She had not been previously notified by staff that Resident #4 had rubbed her feet or heels together. -She had been unable to stage Resident #4's heel wounds because the wounds were covered with thick dead skin. -She made a referral on 10/01/20 for Resident #4 to go to the wound clinic. -Resident #4 may need debridement of her wounds before the wounds could be staged. (Debridement is the removal of damaged from a	D 269		

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wound).
-Resident #4 was normally seated in her wheelchair with her feet hanging down on the foot rest.
-She did not know how often staff had checked Resident #4's feet.
-She had expected staff to check Resident #4's feet daily.
-Resident #4's heels could have been blanching and discolored a few days before she had been notified on 09/23/20.
-She expected staff to not walk Resident #4 because of her unstageable pressure ulcers.
-Walking Resident #4 with her unstageable pressure ulcers would cause pain and increase the chances of Resident #4 to develop an infection.
-To reduce the development of pressure ulcers, she expected staff to turn and reposition Resident #4 every 2 hours.
-She expected staff to get Resident #4 out of her wheelchair every 2 hours and not leave her in her wheelchair for "extended amounts of time."

Interview with the Facility Manager on 10/01/20 at 11:44am revealed:
-PCAs should be checking residents' feet daily when they put their socks and shoes on.
-She did not know if the PCAs had been checking the residents' feet daily.
-Staff were not required to document foot care of residents.
-When PCAs completed Resident #4's showers, they should have been looking at her feet for any changes.
-She did not know Resident #4 had unstageable pressure ulcers to her heels.
-Resident #4 was able to walk with staff assistance.
-She did not know if Resident #4 could move

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D 269	Continued From page 19 herself while she had been in bed. -She had expected residents to be taken to the bathroom for toileting every 2 hours. Interview with the Administrator on 09/30/20 at 4:50pm revealed he expected staff to provide personal care assistance to all residents as per their assessed needs. _____ The facility failed to provide assistance with repositioning to Resident #4 who had a documented history of frail skin and was totally dependent upon staff for bathing, dressing, ambulation, and foot care. The resident was ordered home health services from 07/03/20 - 08/25/20 which included services for pressure ulcer prevention. The home health nurse taught the staff how to complete a proper skin assessment and pressure release options for Resident #4 which included different turning positions and teaching the staff how to reposition the resident every 2 hours unless otherwise ordered by a physician. Resident #4 was left in her wheel chair for more than two hours at a time, with her feet on the wheel chair's footrest, rubbing against each other, or flat on the floor creating pressure points to her heels. The facility's failure resulted in unstageable ulcers on both of Resident #4's heels, placing the resident at risk of requiring wound debridement and infection, and resulted in the need for specialty wound care from a wound clinic all of which was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 1, 2020 for this violation. THE CORRECTION DATE FOR THE TYPE B	D 269		

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D 269	Continued From page 20 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2020.	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. This Rule is not met as evidenced by: 1 TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision to 2 of 3 sampled residents (#2, #3) with cognitive impairment and mental health diagnoses who resided on the special care unit (SCU). The findings are: Review of the facility's special care unit (SCU) policy revealed: -When a resident became aggressive and was a threat to him/herself or others, an attempt was made to isolate the resident until calm. -The family was notified and if the behavior continued, as needed (PRN) medication was requested for the resident's physician. -If the behavior became too severe and unmanageable then an emergency response team would be called, and the resident will be discharged to an emergency mental health facility or to the hospital. 1. Review of Resident #3's current FL-2 dated	D 270		

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D 270	Continued From page 21 10/20/19 revealed: -Diagnoses included Alzheimer's, dementia psychosis, lymphoid leukemia, hyperlipidemia, insomnia, hypertension, gastroesophageal reflux disease, and hypokalemia. -Resident #3's level of care was documented as special care unit (SCU) -Resident #3 was ambulatory, constantly disoriented, wandered, and incontinent. -Resident #3 required assistance with bathing, feeding, and dressing. Review of Resident #3's care plan dated 09/23/20 revealed: -Resident #3 was always disoriented. -Resident #3 required total assistance with toileting, bathing, dressing, and grooming. -Resident #3 required supervision with ambulation and transferring. Observation of the SCU on 09/24/20 from 12:30pm - 12:48pm revealed: -Resident #3 was in the television room with 7 other residents. -Resident #3 was observed climbing on a chair. -Resident #3 was observed pulling at the electrical cords to the television cable box. -There was no staff present to supervise the resident and no staff checked on the resident during this 18- minute timeframe. Interview with a medication aide/supervisor (MA/S) on 09/24/20 at 12:37pm revealed: -Resident #3 hit another resident 2 to 3 months ago. -She did not remember the exact date that the incident had occurred. -She had written the incident down in the supervisor's notebook that was kept at the nurses' station.	D 270		

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-The supervisor's notebook was where the MA/Ss would document any resident accident and incidents or report they needed to pass to the next MA/S.
-She did not remember if she had completed an incident and accident report.
-All incident and accident reports were kept in the Facility Manager's office.
-She looked in the Facility Manager's office and had not found an incident and accident report of Resident #3 slapping another resident.
-MA/Ss were responsible for filling out incident and accident reports.
-She would have notified Resident #3's PCP of her behaviors if she had noticed a pattern and the resident had continued to hit or slap other residents on a daily basis.
-She did not remember if she had notified Resident #3's PCP that she had slapped another resident.
-She had documented the incident in the supervisor's notebook.
-She documented the incident on a physician's note form and put the form in the resident's chart.
-She would "constantly" check on Resident #3 to be certain the resident was safe.

Review of Resident #3's the physician's note forms in Resident #3's record on 09/24/20 from 12:45 - 1:06pm revealed there was no documentation of the incident in which Resident #3 slapped another resident documented on a physician's note form in the resident's record.

Interview with a nursing assistant (NA) on 09/24/20 at 12:49pm revealed:
-Two days ago, Resident #3 threw a plate and a cup at another resident sitting across the table from her in the dining room during lunch.
-Resident #3 threw plates at the same resident

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twice last week.
-Resident #3 would walk up to other residents and "slap" them on the arms.
-Resident #3 was "combative."
-The resident's PCP was not always told about a resident's behavior unless the behavior was "real bad".
-An example of "real bad" would be if a resident was bitten, kicked, pushed down, or fell because they were grabbed.
-Three months ago, Resident #3 picked up the cable box and threw it on the floor in the television room of the Special Care Unit (SCU), breaking the cable box.
-Resident #3 had destroyed three cable boxes in the last six months.
-On two separate occasions, Resident #3 poured milk in to the cable box while the cable box was plugged into an electrical outlet.
-Resident #3 broke the toilet tank lid by picking up the lid and dropping it on the floor on two separate occasions. The last time was about two - three months ago.
-She did not know if the facility had a policy or what the procedure was for residents with behaviors.
-Resident #3 would require "constant" checks by staff to ensure safety.
-The MA/s was told about Resident #3's behaviors.

Telephone interview with the Facility Manager on 09/25/20 at 10:08am revealed:
-Resident #3 had poured milk in the cable box two - three months ago.
-Resident #3 was unsupervised at that time.
-Resident #3 was already pouring milk in the cable box when the Activity Director walked in and saw her.
-She was concerned for Resident #3's safety

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because pouring milk in the cable box was an electrical hazard and the resident was unsupervised.
-Resident #3 had hit a resident in the past (no dates provided).
-Resident #3 broke a toilet tank lid about four weeks ago.
-Resident #3 had not had any other behavior disturbances.

Telephone interview with Resident #3's primary care provider (PCP) on 09/28/20 at 12:29pm revealed:
-She last saw Resident #3 on 09/23/20 in the facility.
-During her visit on 09/23/20, she and the SCU staff were unable to locate Resident #3 in the SCU.
-The SCU staff did not know where Resident #3 was in the SCU.
-She looked for Resident #3 in each resident room in the SCU and the resident in an empty resident room in the SCU, standing behind a recliner looking out of the window.
-She was not been notified by staff that Resident #3 had poured a liquid in the television cable box in the SCU.
-She had not been notified by staff that Resident #3 had slapped other residents or thrown her meal tray and hit other residents.
-She expected to be notified by staff that Resident #3 had poured a liquid in the television cable box, slapped other residents, and thrown her meal tray at residents.
-She was concerned that the resident may need increased supervision and may need her medications adjusted.
-She would have ordered the resident to be placed on 15-minute checks by staff until she was able to see a mental health provider if she had

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been notified.
-She would have adjusted Resident #3's medication if she had known that the resident was pouring liquids in the television, slapping other residents, and throwing her meal try at other residents.

Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.

Refer to interview with a nursing assistant (NA) on 09/24/20 at 12:49pm

Refer to second interview with the MA/S on 09/24/20 at 1:41pm.

Refer to telephone interview with the Facility Manager on 09/25/20 at 10:08am.

Refer to the second telephone interview with the Facility Manager on 09/25/20 at 10:40am.

Refer to telephone interview with the facility's contracted PCP on 09/28/20 at 12:00pm

Refer to telephone interview with the Administrator on 09/30/20 at 4:47pm.

2. Review of Resident #2's current FL-2 dated 11/06/19 revealed:
-Diagnosis included Alzheimer's and stroke.
-The resident was intermittently disoriented, ambulatory, incontinent of bowel and bladder, and required assistance with bathing, feeding, and dressing.

Review of Residents #2's current Care plan dated 09/23/20 revealed:
-The resident required supervision with eating,

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WOODARD'S RETIREMENT VILLAGE	1019 ROYAL AVENUE GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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ambulation, and transferring.
-The resident required extensive assistance with toileting, bathing, dressing, and grooming.
-The resident had a history of mental illness, was receiving medications for mental illness and behaviors, and was under the care of a mental health provider.
-The resident was sometimes disoriented, forgetful and needed reminders, and was incontinent of bowel and bladder.

Review of Resident #2's previous care plan dated 07/01/20 revealed:
-The resident required supervision with eating, ambulation, and transfers.
-The resident required extensive assistance with toileting, bathing, dressing, and grooming.

Observation of the SCU on 09/24/20 from 12:30pm - 12:48pm revealed:
-Resident #2 was sitting in a wheelchair located in the television room of the Special Care Unit (SCU) with 7 other residents.
-The resident was waving her arms, pointing at another resident, and yelling "get her".
-There was a deep purple discoloration extending from the residents left mid hand to just below the elbow which covered the entire front part of the left arm.
-There was a bluish gray discoloration oblong in shape located on the inside of the residents left wrist.
-There was a dark red to plum colored discoloration oblong in shape with the edges grayish yellow in color located on the inside of the residents left distal forearm.
-There were scattered bruises smaller in size on the inside of the residents left forearm.
-There was no staff present to supervise the resident and no staff checked on the resident

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D 270	Continued From page 27 during this 18- minute timeframe. Review of handwritten documentation for the 11:00pm - 7:00am shift dated 09/22/20 revealed: -A bruise was discovered on Resident #2's arm which "probably" occurred on 09/21/20 just before 7:00am during a "hands on altercation" with another resident. -The staff member had to "run" to separate Resident #2 and the other resident immediately. -Resident #2 was hitting another resident. -The other resident was defending herself. -There was documentation that read "09/21/20 11:00pm actual documentation time". Review of handwritten documentation for the 11:00pm - 7:00am shift dated 09/23/20 revealed: -The 09/21/20 incident between Resident #2 and another resident was not witnessed. -Resident #2 and the other resided had to be separated for hitting each other and verbal altercations. Review of an accident/incident report dated 09/22/20 revealed: -Resident #2 was placed in the television room in her wheelchair by staff. -Another resident sat beside Resident #2. -Staff exited the television room to assist another resident with toileting. -Staff overheard a "commotion" in the television room. -Staff "ran" in the television room and observed Resident #2 and another resident "hitting and slapping" at each other. -Staff separated Resident #2 and the other resident. -The incident occurred on 09/21/20 at	D 270		

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D 270	Continued From page 28 approximately 6:45am. Interview with a nursing assistant (NA) on 09/24/20 at 12:49pm revealed: -Resident #2 was wheelchair bound and confused. -Resident #2 was in a physical altercation with another resident during the end of 3rd shift on 09/21/20. Telephone interview with the Facility Manager on 09/25/20 at 9:58am revealed: -Resident #2 could be "combative and agitated at times." -Resident #2 was in an altercation with another resident during the end of 3rd shift on 09/21/20. Telephone interview with Resident #2's mental health provider on 09/28/20 at 9:18am revealed Resident #2 had ongoing agitation due to psychosis and dementia. -Resident #2 had not been seen since 02/03/20 because her follow up appointment was canceled and not rescheduled. -It was difficult to determine Resident #2's current supervision needs because the resident had not been evaluated in several months. Telephone interview with a medication aide/supervisor (MA/S) on 09/28/20 at 9:56am revealed: -Sometimes Resident #2 would try to hit other residents. -When Resident #2 would hit at other residents, staff would remove the resident from the area or verbally redirect the resident. -Resident #2 required as needed medication for anxiety on eleven out of twenty-eight days for the month of September 2020.	D 270		

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Telephone interview with Resident #2's mental health provider on 09/29/20 at 1:41pm revealed:
-He had a virtual visit with the resident today, 09/29/20.
-Today, 09/29/20, staff reported Resident #2's mental health condition and behaviors had worsened since March 2020.
-Resident #2 required medication adjustments because of her behaviors.

Telephone interview with Resident #2's Power of Attorney (POA) on 09/30/20 at 2:37pm revealed:
-The resident had a history of fighting, screaming, cursing, and hitting.
-About five or six months ago she was told by staff the resident had gotten "mean" and wanted to "fight" residents.

Telephone interview with Resident #2's primary care provider (PCP) on 10/01/20 revealed she would have ordered every fifteen-minute checks on the resident until she was evaluated by mental health if she had been notified about of the resident's behaviors and altercation which occurred on 09/21/20.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Attempted telephone interview with a personal care aide (PCA) on 09/25/20 at 9:06am was unsuccessful.

Refer to interview with a nursing assistant (NA) on 09/24/20 at 12:49pm

Refer to second interview with the MA/S on 09/24/20 at 1:41pm.

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D 270	Continued From page 30 Refer to telephone interview with the Facility Manager on 09/25/20 at 10:08am. Refer to the second telephone interview with the Facility Manager on 09/25/20 at 10:40am. Refer to telephone interview with the facility's contracted PCP on 09/28/20 at 12:00pm Refer to telephone interview with the Administrator on 09/30/20 at 4:47pm. _____ Interview with a MA/S on 09/24/20 at 1:41pm revealed: -5 residents on the SCU required 2:1 (2 staff per one resident) personal care assistance. -It would take 20 - 30 minutes to provide personal care to each resident who required 2:1 personal care assistance. -There were three residents in the SCU who exhibited aggressive behaviors and were combative by hitting and slapping other residents and using foul language. -She had never been asked by staff to supervise residents in the SCU when SCU staff were performing 2:1 personal care assistance. -There were only 2 personal care aides (PCA's) assigned during 1st, 2nd, and 3rd shift in the SCU. -There was one MA/S on duty each shift who was assigned to cover the SCU and the assisted living during 1st, 2nd, and 3rd shift. -She was not aware if the facility had a supervision policy. -If there had been a resident to resident incident, the primary care provider would not always be notified unless the incident was really bad. -A "real bad" incident would involve a resident biting, hitting, or pushing down another resident.	D 270		

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D 270	Continued From page 31 Interview with a nursing assistant (NA) on 09/24/20 at 12:49pm revealed: -She and the PCA were providing personal care for a resident at 12:30pm today, 09/24/20. -That resident required 2:1 assistance and took greater than ten minutes to provide the personal care; the remaining residents in the SCU were unsupervised. -There were three residents on the 7:00am - 3:00pm shift who required showers and dressing. -Those three residents for the 7:00am - 3:00pm shift required 2:1 personal care assistance. -It would take twenty minutes to bath and dress residents who required 2:1 personal care assistance. -When providing personal care to residents who required 2:1 staff assistance there was no staff to supervise the other residents in the SCU. -She had never asked for extra staff to supervise the residents in the SCU when providing 2:1 personal care assistance because there was only one personal care aide (PCA) on the assisted living (AL) side and one MA/S for the entire facility. -There were no residents in the SCU who required increased supervision. -She did not know of any residents in the SCU who had ever been on increased supervision. Telephone interview with the Facility Manager on 09/25/20 at 10:08am revealed: -There were 11 residents in the SCU. -There were always two staff in the SCU on first, second, and third shift. -There was always one MA/S worked during first, second, and third shift and covered the SCU and AL. -All residents are checked on every two hours. -All the residents in the SCU required increased	D 270		

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supervision at some point, but not every day or all day
-None of the SCU residents were currently on increased supervision.
-There was a total of 4 residents in the SCU who required 2:1 personal care assistance.
-She did not long how long it would take to provide personal care for those residents.
-There were some residents in the SCU who were combative and/or agitated at times.
-When 2:1 personal assistance was required, "sometimes" the AL PCA would supervise the residents in the SCU.
-She did not know when the AL PCA last supervised residents in the SCU.
-The Activity Director had to supervise residents for SCU staff about two - three months ago while staff provided 2:1 personal assistance.
-If a resident in the SCU became agitated and/or required 2:1 personal assistance the other residents would be no staff to supervise the other residents.
-She did not know what her expectations were for supervision of staff and residents when SCU staff were performing 2:1 personal care.
-The SCU residents would sit in the lounge or television room when staff were performing 2:1 personal assistance.
-The residents in the lounge or television room would be unsupervised.
-She had no concerns for the residents that would be left unsupervised.
-SCU staff would call the MA/S if they needed someone to supervise the residents.
-When residents on the SCU got into a fight, the personal care aide was expected to notify the MA/S.
-The MA/S was supposed to write the incident down in an incident and accident report.
-The MA/S was supposed to send the incident

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and accident report to the resident's primary care provider, (PCP) the local department of social services, and the family.
-The MA/S was supposed to notify the oncoming MA/SIC verbally or by writing the incident down in the supervisor's notebook that is kept at the nurses' station.

Second telephone interview with the Facility Manager on 09/29/20 at 10:40am revealed:
-The facility did not have a supervision policy.
-Staff had been trained when they were hired on how to supervise residents.
-If staff had any questions about supervision, they could refer to their job description.
-She only called the PCP when she needed a medication refill or if she needed authorization for something.

Telephone interview with the facility's contracted PCP on 09/28/20 at 12:00pm revealed:
-All residents in the SCU were incontinent and required 2:1 assistance to perform incontinent care.
-There needed to be one additional staff person on duty in the SCU to supervise the residents when personal care was being performed by the staff.
-She was concerned that residents were not supervised by staff when they were performing personal care to other residents.
-Staff should always know where every resident was.
-Every resident in the SCU was at risk for falls.
-It was unacceptable to leave residents unsupervised because of safety concerns such as falls and disruptive behaviors.
-There should always be a staff in the SCU television room when it was occupied by residents.

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D 270	Continued From page 34 -Staff should be positioned to where they could see residents in the television room and visualize the hall to supervise the residents. Telephone interview with the Administrator on 09/30/20 at 4:47pm revealed: -Residents in the SCU were checked on "frequently" by the PCAs that worked in the SCU during each shift. -He expected the MA/S to notify the Facility Manager immediately if there was a concern of increased behaviors. -He expected staff on SCU to notify the MA/S on duty to supervise the residents' in SCU as need when they were providing personal care to other residents. Refer to 10A NCAC 13F. 1308a Special Care Unit Staffing. _____ The facility failed to provide supervision for residents in the Special Care Unit with cognitive impairment and mental health diagnoses resulting in 3 of 3 sampled residents being left unsupervised for 18 minutes while staff provided personal care to another resident. Resident #3 who was combative, confused, would hit other residents, was left unsupervised and poured milk into a cable box on two different occasions while it was plugged into an electrical outlet, creating an electrical hazard. Resident #1 and Resident #2 had an altercation while unsupervised resulting in Resident #2 being bruised from her left hand to just below her left elbow. The facility's failure placed the residents at substantial risk of serious physical harm, abuse, and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 2,	D 270		

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D 270	Continued From page 35 2020 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2020.	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 observations, interviews, and record reviews, the facility failed to ensure the routine and acute health care needs were met for 4 of 4 sampled residents (#1, #2, #3, #4,) related to failing to notify the primary care provider (PCP) of three residents exhibiting behaviors harmful to themselves and /other residents (#1, #2, #3); failing to notify the PCP of a physical altercation between two residents resulting in bruising to one resident in which the injury was not reported to the PCP (#1, #2); failing to ensure PCP notification and emergent medical evaluation of an oxygen saturation result of 75% and blood pressure of 72/33 and a fall with a head injury (#3); failure to ensure three residents attended medical appointments as ordered (#1, #2, #3); and a delay in setting up home health for a resident with pressure ulcers (#4). The findings are: 1. Review of Resident #3's current FL-2 dated	D 273		

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D 273	Continued From page 36 10/20/19 revealed: -Diagnoses included Alzheimer's, dementia psychosis, lymphoid leukemia, hyperlipidemia, insomnia, hypertension, gastroesophageal reflux disease, and hypokalemia. -Resident #3's level of care was documented as special care unit. -Resident #3 was ambulatory, constantly disoriented, wandered, and incontinent. Review of Resident #3's care plan dated 09/23/20 revealed: -Resident #3 was constantly disoriented. -Resident #3 required total assistance with toileting, bathing, dressing, and grooming. -Resident #3 required supervision with ambulation and transferring. a. Review of the facility's house policy for blood pressures revealed: -Residents' blood pressures were checked once a week and recorded on their medication administration record (MAR). -Staff were instructed to call the provider if the systolic blood pressure was greater than 180 or less than 90. -Staff were instructed to call the provider if the diastolic blood pressure was greater than 100 or less than 40. -This policy had been signed by the facility's Administrator. -This policy had been signed by the facility's contracted primary care provider. Review of Emergency (ER) provider note for Resident #3 dated 07/21/20 revealed: -Resident #3 was admitted to the hospital with a diagnosis of syncope. -Resident #3 had a syncopal episode due to a low heart rate.	D 273		

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D 273	Continued From page 37 -Resident #3's heart rate was found to be in the low 40's when she had arrived at the ER. Review of handwritten correspondence to Resident #3's primary care provider (PCP) dated 08/19/20 revealed: -Resident #3's vitals signs were documented as blood pressure 72/33 and oxygen saturation of 75%. -The resident went "into her sleeping mode after breakfast." -The staff contacted Resident #3's power of attorney (POA) to see if the POA wanted the resident sent to the hospital. -The family member told staff not to send the resident to the hospital, "to just keep a check on her." Interview with a medication aide/supervisor (MA/S) on 09/29/20 at 8:37am revealed: -She was on duty and had taken Resident #3 vital signs on 08/19/20. -Resident #3 was not sent to the hospital on 08/19/20 when her vital signs had been documented as blood pressure 72/33 and oxygen saturation of 75%. -She had not called Resident #3's PCP. -She called Resident #3's power of attorney (POA) who had refused for the resident to go to the ER. -Resident #3's POA had requested that he be called before the resident was sent out the ER. -Resident #3 went to her room and fell asleep after she had spoken with the POA. -The facility had blood pressure policy. -All residents blood pressures were checked every Saturday. -She did not know what the blood pressure policy parameters were or where the blood pressure policy was located.	D 273		

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D 273	Continued From page 38 -Resident #3 had no blood pressure orders. Interview with Resident #3's PCP on 09/28/20 at 12:56pm revealed: -She was not notified by the MA/S immediately of Resident #3's blood pressure of 72/33 and oxygen saturation of 75% on 08/19/20. -She expected to be called by the MA/S immediately after getting low pressure reading. -She told the MA/S when they got a low blood pressure reading with the automatic blood pressure cuff, they were supposed to check the blood pressure manually. -If they residents blood pressure was still after the manual reading, she had expected staff to call 911 immediately. -She was not notified if the MA/S had tried to recheck Resident #3's blood pressure with a manual blood pressure cuff. -She would have expected Resident #3 to go to the ER after the low blood pressure reading of 72/33. -Family should not be called first, 911 should have been the first phone call. -She was concerned because if Resident #3 had tried to walk with a low pressure and low oxygen saturation she could have passed out and fallen which could have caused serious injuries. Interview with Resident #3's POA on 09/30/20 at 3:39pm revealed: -He had received a call from the facility on 08/19/20 that Resident #3's blood pressure was low (72/33) and oxygen saturation was 75%. -He refused to have Resident #3 sent to the ER because she had a history of syncopal episodes. -He had instructed the facility staff to call him before sending Resident #3 to the ER because she had a history of syncopal episodes. -He had not wanted her transferred to the ER	D 273		

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because he had been concerned with the potential exposure to COVID-19.

Interview with the Facility Manager on 09/29/20 at 10:40am revealed:
-She knew that Resident #3 had a blood pressure of 72/33 and oxygen saturation of 75% on 08/19/20 and had expected the MA/S to call emergency medical services (EMS) first and then send Resident #3 to the ER.
-Resident #3 had been sent to the ER in the past for syncopal episodes and the doctors had not been able to find anything wrong with the resident.
-Resident #3 had syncopal episodes in the past and her POA had refused for her to go to ER.
-Resident #3's POA had requested the staff contact him before sending Resident #3 to the hospital for syncopal episodes.

Interview with the Administrator on 09/30/20 at 4:00pm revealed:
-He did not know about Resident #3's low blood pressure of 72/33 and oxygen saturation of 75% on 08/19/20.
-The MA/S should not have notified the PCP by sending a fax. The PCP should have been notified by phone immediately once she received the blood pressure of 72/33 and oxygen saturation of 75%.
-The PCP was available by phone 24 hours per day and 7 days per week.
-The PCP would have told the MA/S what to do.
-If the MA/S could not reach the PCP by phone, he expected the MA/S to send Resident #3 to the ER.

b. Interview with Resident #'3's family member/Power of Attorney (POA) on 09/30/20 at 3:24pm revealed:

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D 273	Continued From page 40 -He had received a call from a medication aide/supervisor (MA/S) on 09/26/20 around 7:45pm that Resident #3 had a fall. -The MA/S told him that the resident had a small cut to her head. -He was asked did he want Resident #3 to go to the Emergency Room (ER). -He refused to have the facility send Resident #3 to the ER, because it had only been a small cut. -Another family member visited Resident #3 on 09/27/20 at the facility. -The other family member reported to him that Resident #3 had a large wound to her forehead. -He went to the facility on 09/27/20 to visit Resident #3 and examine the wound. -On 09/27/20, he discovered the wound was larger than what was reported to him by the MA/S. -He did not know the cut was a large wound. -He requested the MA/S on duty transport the resident to the ER on 09/27/20. -The MA/S called the Facility Manager to speak with the family member. -The Facility Manager advised the family member that he had to transport the resident to the ER because the facility did not have enough staff to transport the resident to the ER and it was not an emergency. -He had transported Resident #3 to the ER. -Resident #3 received three stitches to the wound on her head. -If he had known she had a large wound on her forehead, he would have requested she be sent to the ER on 09/26/20. Review of the ER Provider note for Resident #3 dated 09/27/20 revealed: -Resident #3 arrived in the ER at 8:40pm with a family member after an unwitnessed fall on 09/26/20 that caused a laceration to her head.	D 273		

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D 273	Continued From page 41 -Resident #3 had a 2-centimeter laceration noted to the right of her eye. -Resident #3 had received 3 sutures to the laceration to the right of her eye. -Resident #3 had a CT scan of her head and cervical spine with no acute findings. -Resident #3 was at her baseline and was discharged from the ER on 09/27/20. Interview with the a personal care aide (PCA) on 10/01/20 at 4:46pm revealed: -She was one of the PCAs that was working on 09/26/20 when Resident #3 fell around 7:00pm. -She and the other PCA on duty had been in another resident's room trying to get the resident ready for her shower. -Resident #3 had been in the television room in the SCU. -The PCA from the assisted living (AL) section of the facility had been giving the residents in the SCU snacks. -The PCA from the AL section of the facility was in another room in the SCU. -The PCA from the AL heard a resident scream and ran to the television room and found Resident #3 on the floor. -Resident #3 had blood dripping from her right eye. -She assisted Resident #3 and placed her on the couch in the television room. -She pressed the call bell in the television room to notify the MA/S that she had needed help in the SCU. -The MA/S entered the SCU and placed a cloth on Resident #3's wound above her right eye to stop the bleeding. -The MA/S called Resident #3's POA. -The MA/S told her that Resident #3's POA had refused for Resident #3 to go to the ER. -She did not know if the facility had a policy on	D 273		

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what staff was supposed to do if a resident had a fall with a head injury in the SCU.
-She did not know if a resident needed to be sent to the ER if they had a head injury.
-She was trained by the first MA/S.
-She did not know if Resident #3's PCP had been notified of the fall.
-She did not know if Resident #3's PCP should have been notified of the fall.
-Resident #3 had responded as normal after she had fallen.
-She had checked on Resident #3 every 15 minutes to make sure Resident #3 had been ok.
-She had not been instructed to check on Resident #3 and she had not documented the 15 checks she had completed.
-Resident #3's family came to the facility on 09/27/20 to visit her and requested she remove the bandage on her eye.
-The family member left and then returned with Resident #3's POA.
-The family members requested that Resident #3 be transported to the ER.
-She had notified the MA/S of the family members' request.
-The resident had received 3 stitches to the wound above her right eye after being taken to the ER by her family member.

Interview with a MA/S on 10/02/20 at 12:04pm revealed:
-She was the MA/S that was working on 09/26/20 when Resident #3 had fallen.
-She had been passing out medicine to residents on the AL, when she was notified by a PCA from the SCU that Resident #3 had fallen.
-She went to the SCU to check on Resident #3.
-Resident #3 was sitting on the couch and she had a cut above her right eye.
-She applied a cloth and pressure to Resident

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D 273	Continued From page 43 #3's cut to stop the bleeding. -She first called the Facility Manager to find out how she needed to respond to the accident. -The Facility Manager did not answer the phone. -She called the a (named) MA/S, who advised her to call the POA to determine if he wanted Resident #3 transferred to the ER. -She called the resident's POA and she advised him that the resident had fallen, and had a cut above her right eye. -Resident #3's POA refused to send the resident to the ER. -She notified the PCAs that the resident would not be transported to the ER. -She cleaned and placed a bandage on Resident #3's cut. -She checked on the resident every 30 minutes to 1 hour, and she documented the checks in a composition notebook at the nurses' station. -She was not told to check on the resident every 30 minutes to 1 hour or to have those checks documented. -She had talked to the Facility Manager who had advised her to document the fall in an incident and accident (I&A) report. -The Facility Manager had advised her to fax the I&A report to Resident #3's Primary Care Physician (PCP). -She completed and faxed the I&A report to the resident's PCP, she did not remember what time she had sent the fax. -She had not received a response from the PCP before leaving at the end of her shift at 11:00pm. -She did not know if the facility had a policy on what staff was supposed to do if a resident had a fall with a head injury in the SCU. -She did not know if Resident #3 was supposed to go to the ER because she had a fall with a head injury.	D 273		

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D 273	Continued From page 44 Interview with Resident #3's PCP on 10/01/20 at 9:43am revealed: -She had been notified of Resident #3's fall on 09/26/20 via fax. -She did not know when the faxes were received at her office. -She did not check the fax machine at her office on 09/26/20 or 09/27/20. -She did not usually check her fax machine on the weekend. -She expected to be notified by phone of Resident #3's fall immediately after the fall had occurred. -She expected to be notified of all falls with head injuries immediately. -She was concerned that Resident #3 had not gone to the ER on 09/26/20. -Resident #3 could have had a brain bleed or other head trauma that could have resulted in death. Interview with the Facility Manager on 10/01/20 at 11:03 revealed: -She was aware of Resident #3's fall that had occurred on 09/26/20. -The POA refused for Resident #3 to go to the ER. -She expected the MA/S on duty to call 911 immediately after a resident had fallen with a head injury. -Staff would have been trained when they first started working at the facility that they were expected to immediately call 911 when a resident had a fall with a head injury. -She expected the MA/S on duty to notify the PCP of Resident #3's fall by sending her a fax of the I&A report. -She expected the MA/S on duty to send a subsequent fax before the end of their shift to the PCP if she had not responded to the first fax.	D 273		

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D 273	Continued From page 45 -She expected the MA/S on duty to call the PCP before the end of their shift if they had not responded to the second fax. -She did not know if the PCP received faxes on the weekend. Interview with the Administrator on 10/01/20 at 2:33pm revealed: -He had been notified about Resident #3's fall by the Facility Manager. -He had expected the MA/S to call 911 immediately after Resident #3 fell and had a head injury. -He did not know why Resident #3 was not sent to the ER after her fall. c. Interview with a medication aide/supervisor (MA/S) on 09/24/20 at 12:37pm revealed: -Resident #3 hit another resident 2 to 3 months ago. -She did not remember the exact date that the incident had occurred. -She had written the incident down in the supervisor's notebook that was kept at the nurses' station. -The supervisor's notebook was where the MA/Ss would document any resident accident and incidents or report they needed to pass to the next MA/S. -She did not remember if she had completed an incident and accident report. -All incident and accident reports were kept in the Facility Manager's office. -She looked in the Facility Manager's office and had not found an incident and accident report of Resident #3 slapping another resident. -MA/Ss were responsible for filling out incident and accident reports. -She would have notified Resident #3's PCP of her behaviors if she had noticed a pattern and the	D 273		

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resident had continued to hit or slap other residents on a daily basis.

Interview with a nursing assistant (NA) on 09/24/20 at 12:49pm revealed:
-Two days ago, Resident #3 threw a plate and a cup at another resident sitting across the table from her in the dining room during lunch.
-Resident #3 threw plates at the same resident twice last week.
-Resident #3 would walk up to other residents and "slap" them on the arms.
-Resident #3 was "combative."
-The resident's PCP was not always told about a resident's behavior unless the behavior was "real bad".
-An example of "real bad" would be if a resident was bitten, kicked, pushed down, or fell because they were grabbed.
-She did not know if the facility had a policy or what the procedure was for residents with behaviors.
-Three months ago, Resident #3 picked up the cable box and threw it on the floor in the television room of the Special Care Unit (SCU), breaking the cable box.
-Resident #3 had destroyed three cable boxes in the last six months.
-On two separate occasions, Resident #3 poured milk in to the cable box while the cable box was plugged into an electrical outlet.
-Resident #3 broke the toilet tank lid by picking up the lid and dropping it on the floor on two separate occasions. The last time was about two - three months ago.
-Resident #3 would require "constant" checks by staff to ensure safety.
-She did not know if Resident #3's PCP had been informed of the resident's assault on the other residents, throwing plates and cups, pouring milk

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in the cable box, throwing the cable box on the floor, and breaking the toilet tank lid.
-She told the MA/S about Resident #3's behaviors.
-She did not tell Resident #3's PCP of the resident's behaviors.

Telephone interview with the Facility Manager on 09/25/20 at 10:38am revealed:
-She knew Resident #3 had destroyed the cable box by pouring milk in it about two -three months ago.
-She did not know Resident #3 had poured milk in the cable box more than once.
-Pouring milk in a cable box was an electrical hazard placing the residents at risk for harm.
-She knew Resident #3 had once slapped another resident in the past. She did not know it had happened more than once. She did not know when the assault occurred.
-She knew Resident #3 had thrown her plate and cup once. She did not know it happened more than once. She did not know when it happened.
-The MA/S told her Resident #3 broke the toilet tank lid about four weeks ago.
-The (named) MA/S had notified Resident #3's PCP about the resident pouring milk in the cable box and hitting another resident.
-She did not know when Resident #3's PCP was notified.
-She expected resident behaviors to be reported to the MA/S by the end of the shift.
-She expected the MA/S to reassess the resident.
-She expected the MA/S to report residents' behaviors to her.
-The PCP should be notified of behaviors only if a resident placed their hands on another resident resulting in injury.

Interview with Resident #3's Primary Care

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D 273	Continued From page 48 Provider (PCP) on 09/28/20 at 12:29pm revealed: -She had not been notified by staff that Resident #3 had poured a liquid in the television cable box in the SCU. -She had not been notified by staff that Resident #3 had slapped other residents or thrown her plate and hit other residents. -She expected to be notified by staff that Resident #3 had poured a liquid in the television cable box, slapped other residents, and threw plates at other residents. -She was concerned that the resident may need increased supervision and her medications adjusted. -She would have ordered the resident to be on 15-minute checks until she was able to see a mental health provider if she had been notified. -She would have adjusted Resident #3's medication if she had known that the resident was pouring liquids in the television, slapping other residents, and throwing her plate at other residents. Interview with the Administrator on 09/30/20 at 4:47pm revealed: -He expected the MA/S to notify the Facility Manager immediately if there had been a concern of increased behaviors. -He expected the PCP to be notified of behaviors harmful to themselves or other residents. d. Review of an Emergency Room (ER) provider note for Resident #3 dated 05/02/20 revealed: -Resident #3 was sent to the ER on 05/02/20 at 5:17pm, with a complaint of mouth lesions and a low-grade temperature of 100.7 degrees Fahrenheit. -Staff at the facility had reported to emergency medical services (EMS) that Resident #3 had an onset of an abscess/ulcer to the inside of her	D 273		

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mouth last night, 05/01/20.
-Resident #3 had a 2-millimeter dark red lesion on the right upper gingiva around the area where the lateral incisor and canine would be.
-Resident #3 was discharged back to the facility on 05/02/20.

Review of handwritten correspondence to Resident #3's PCP dated 05/02/20 revealed:
-Resident #3 had a swollen lower right jaw and had a temperature of 100.2 degrees Fahrenheit (F).
-Resident #3 would not allow staff to examine her mouth.
-Resident #3's Power of Attorney (POA) had been notified.
-Resident #3 was sent to the ER on 05/02/20 via emergency medical services at 4:45pm.
-Resident #3 had returned with two new orders; Tylenol 325mg as needed for fever and Augmentin (an antibiotic that treats infection) 875-125mg two times a day for seven days for "mouth disease".
-The ER nurse had reported to facility staff that the ER physician considered the swelling and temperature due to Resident #3 had rotten teeth.
-The ER physician had encouraged Resident #3 to follow-up with her PCP.
-Resident #3 had returned to the facility around 9:15pm on 05/02/20.
-The ER had administered the first dose of Augmentin to Resident #3.

Review of a handwritten referral for Resident #3 dated 05/02/20 revealed:
-Resident #3's dentist had been unable to perform a full exam on 05/02/20 because Resident #3 had been unwillingly to allow the dentist to look in her mouth.
-Resident #3's dentist had referred the resident to

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an oral and maxillofacial surgeon.
-Resident #3 had an appointment scheduled with the oral and maxillofacial surgeon on 06/08/20 at 3:30pm.
-Resident #3's dentist had signed the referral and appointment correspondence.

Telephone interview with the Patient Care Coordinator at the oral and maxillofacial surgeon's office on 09/28/20 at 12:03pm revealed:
-Resident #3 had been a no call, no show for her appointment scheduled on 06/08/20 at 3:30pm.
-A no call, no show meant that the office had not received a call that Resident #3 would not be attending the appointment and she had not shown up to the appointment.
-The missed appointment had not been rescheduled.

Interview with Resident #3's PCP on 09/28/20 at 12:56pm revealed:
-She was aware Resident #3 had poor dental hygiene.
-She was aware Resident #3 went to the dentist on 05/02/20.
-She did not know that Resident #3 had missed her appointment with the oral and maxillofacial surgeon on 06/08/20 at 3:30pm.
-Poor dental health leads to myocarditis (an inflammation of the heart muscle), endocarditis (an infection of the the inner lining of your heart chambers and heart valves), and potentially death.
-Resident #3 had a high risk of the infection reoccurring by missing her appointment with the oral and maxillofacial surgeon.

Interview with a medication aide/supervisor (MA/S) on 09/29/20 at 9:52am revealed:

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-The facility did not have a policy for making medical appointments.
-When a resident goes to an appointment with an outside provider, the outside provider was responsible for scheduling the follow-up appointment or referral.
-The outside medical provider would send a reminder card or write on an order for the follow-up or referral appointment with the resident back to the facility.

Interview with a second MA/S on 09/30/20 at 8:35am revealed:
-The MA/Ss were responsible for scheduling and rescheduling resident appointments.
-The MA/S wrote a note in the supervisor's notebook if a resident had an appointment.
-She did not remember if Resident #3's missed appointment on 06/08/20 had been written in the supervisor's notebook.
-She had called Resident #3's family member about her appointment on 06/08/20 that she had missed with the oral and maxillofacial surgeon.
-Resident #3's family member had told her, he had forgot about the appointment and he was going to reschedule the appointment.
-Resident #3 had not complained about mouth pain and her eating habits had not changed.

Interview with Resident #3's family member on 09/30/20 at 3:24pm revealed:
-He transported the resident to her medical appointments outside of the facility.
-He took Resident #3 to her dentist appointment on 05/02/20.
-Resident #3 did not let the dentist look in her mouth.
-Resident #3's dentist referred her to oral and maxillofacial surgeon.
-Resident #3's dentist gave him the residents

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discharge paperwork, that he gave to the facility when he returned the resident back to the facility.
-He was not aware Resident #3 had an appointment on 06/08/20 at 3:30pm at an oral and maxillofacial surgeon's office.
-The facility had not called him to notify him of the appointment on 06/08/20.

Telephone interview with the Facility Manager on 09/29/20 at 10:15am revealed:
-Resident #3's family was responsible for transporting her to appointments.
-When the family returned the resident to the facility, the family provided the MA/S information on follow up appointments or referral appointments.
-The facility did not have a process in place to ensure that appointments were rescheduled.
-She had never checked to make sure the MA/Ss were making appointments and rescheduling appointments.
-She was not aware that Resident #3 missed her with the oral and maxillofacial surgeon on 06/08/20 at 3:30pm.
-The MA/S should have called Resident #3's family to find out about the missed appointment.
-The MA/S would have called the oral and maxillofacial surgeons office to reschedule the appointment if Resident #3's family had been unable to take the resident to the appointment.
-Resident #3 had not been complaining about mouth pain and she had been eating her meals.
-She expected to be notified by the MA/S when Resident #3 had missed her appointment.

Interview with the Administrator on 09/30/20 at 3:58pm revealed:
-He did not know that Resident #3 had missed her appointment with the oral and maxillofacial surgeon on 06/08/20.

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-He expected staff to ensure residents did not miss any of their medical appointments.
-The Facility Manager was responsible for scheduling and rescheduling resident appointments.
-The Facility Manager should have rescheduled Resident #3's appointment.

Second telephone interview with the Facility Manager on 10/01/20 at 11:32am revealed:
-She did not know that she was responsible for scheduling or rescheduling medical appointments.
-She discussed with the Administrator when she had been hired as the Facility Manager that it would the responsibility of the MA/S to schedule and reschedule appointments.

Attempted telephone interview with Resident #3's dentist on 10/01/20 at 1:05pm was unsuccessful.

2. Review of Resident #4's current FL-2 dated 01/29/20 revealed a diagnosis of Alzheimer's.

Review of Resident #4's care plan dated 09/23/20 revealed:
-Resident #4 required total assistance from staff with bathing, dressing, and grooming.
-Resident #4 used a wheelchair.
-Resident #4 had significant memory loss and must be directed.

Observations of Resident #4 on 09/24/20 from 10:40am - 11:20am revealed:
-The resident was sitting in a wheelchair located in the Special Care Unit (SCU) living room.
-The foot pedals of the wheelchair were not flat, but were raised.
-The resident was wearing socks and her feet were flat with her heels resting on the floor.

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D 273	Continued From page 54 -The resident would intermittently rub her feet against each other and along the floor. -Staff did not reposition the resident or relieve pressure from her feet and/or heels. Virtual observation of Resident #4 on 09/30/20 at 10:10am revealed: -The resident was lying on her right side in bed. There was no padding at the pressure points between the resident's ankles and lower legs. -On the back of the resident's right heel was a dark plum to brown area approximately 2 inches long (") by 3" wide in diameter extending towards the inner aspect of the heel. The skin was dry, cracked, and intact. The area was sunken in deeper than the perimeter of skin around it. -On the resident's outer left heel was a dark plum to brown area approximately 3" in diameter from the mid back of the heel towards the outer aspect. The area was dry, cracked, and skin intact. -The resident did not move her feet away when PCA touched the heel wounds. Review of a handwritten physician's order dated 09/23/20 revealed: -Resident #4's primary care physician (PCP) had ordered a home health nursing evaluation for wound care. -Resident #4 had unstageable pressure ulcers to both her right and left heels. Interview with a medication aide/supervisor (MA/S) on 09/29/20 at 3:13pm revealed Resident #4 had a local home health provider. Interview with the Branch Director/Registered Nurse (RN) of the local home health provider on 10/01/20 at 1:27pm revealed: -They had not received a home health referral	D 273		

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dated 09/23/20 for Resident #4.
-Resident #4's last home health referral was received via fax on 07/03/20.
-Resident #4's home health nursing last visit was on 08/25/20.

Interview with a MA/S on 10/1/20 at 10:44am revealed:
-She was present when Resident #4's PCP had given another a MA/S an order for home health for Resident #4.
-The PCP told both MA/S that she was going to make the referral to home health for Resident #4.
-She called the PCP's office on 09/29/20 to find out why home health had not started for Resident #4.
-She spoken with the PCP's assistant and left a message for a call back.

Interview with Resident #4's PCP on 10/01/20 at 9:28am revealed:
-She had not instructed the MA/S that she would set up the home health referral for Resident #4.
-She written the referral for home health for Resident #4 so the MA/S could send the referral to a home health provider.
-She expected the home health referral to be sent out the same day the order is written 09/23/20 to not delay start of care.
-She expected home health to start for Resident #4 within 48 hours.
-The facility should have notified her in 48 hours if the home health had not started.
-A delay in care could cause Resident #4's unstageable pressure ulcers to become infected.
-The resident could become septic which would lead to death.

3. Review of Resident #2's current FL-2 dated

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D 273	Continued From page 56 11/06/19 revealed: -Diagnosis included Alzheimer's, chronic obstructive pulmonary disease, and stroke. -The resident was intermittently disoriented, ambulatory, incontinent of bowel and bladder, and required assistance with bathing, feeding, and dressing. Review of Residents #2's current Care plan dated 09/23/20 revealed: -The resident required supervision with eating, ambulation, and transferring. -The resident required extensive assistance with toileting, bathing, dressing, and grooming. -The resident had a history of mental illness, was receiving medications for mental illness and behaviors, and was under the care of a mental health (MH) provider. -The resident was sometimes disoriented, forgetful needing reminders, and was incontinent of bowel and bladder. a. Observation of Resident #2 on 09/24/20 at 12:30pm revealed: -The resident was sitting in a wheelchair located in the television room of the Special Care Unit (SCU). -The resident was waving her arms, pointing at another resident, and yelling "get her". -There was a deep purple discoloration extending from the resident's left mid hand to just below the elbow which covered the entire front part of the left arm. -There was a bluish gray discoloration oblong in shape located on the inside of the resident's left wrist. -There was a dark red to plum colored discoloration oblong in shape with the edges grayish yellow in color located on the inside of the resident's left distal forearm.	D 273		

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D 273	Continued From page 57 -There were scattered bruises smaller in size on the inside of the resident's left forearm. Review of handwritten documentation for the 11:00pm - 7:00am shift dated 09/22/20 revealed: -A bruise was discovered on Resident #2's arm which "probably" occurred on 09/21/20 just before 7:00am during a "hands on altercation" with another resident. -Resident #2 was hitting another resident. -The staff member had to "run" to separate Resident #2 and the other resident. -There was documentation that read: "I'm almost sure that is how her wrist became so terribly bruised". -There was no documentation the medication aide/supervisor (MA/S) had been notified. -There was no documentation Resident #2's Primary Care Provider (PCP) had been notified. -There was documentation that read "09/21/20 11:00pm actual documentation time". Review of an accident/incident report dated 09/22/20 revealed: -Resident #2 was placed in the television room in her wheelchair. -Another resident was sitting beside Resident #2. -Staff exited the television room to assist another resident with toileting. -Staff overheard a "commotion" in the television room. -Staff "ran" in the television room and observed Resident #2 and another resident "hitting and slapping" at each other. -Staff separated Resident #2 and the other resident. -Resident #2 and the other resident continued to verbally assault each other across the room requiring staff to intervene "several times".	D 273		

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-The incident occurred on 09/21/20 at approximately 6:45am.
-Staff did not know about Resident #2's "bruise" to the wrist until reporting for the 11:00pm shift on 09/21/20.
-There was no documentation Resident #2's PCP was notified of the accident/injury.

Interview with a personal care aide (PCA) on 09/24/20 at 12:49pm revealed:
-Resident #2 was "normally confused".
-She noticed bruises to Resident #2's left arm on 09/21/20 when showering the resident during 1st shift.
-She did not know how the bruise to Resident #2's left arm occurred.
-She told the medication aide/supervisor (MA/S) about the bruise to Resident #2's left arm on 09/21/20.
-The Facility Manager spoke with Resident #2 about the bruise to the residents left arm.
-A PCA documented a note about Resident #2's bruise in the communication book.
-She did not know if Resident #2's PCP was notified.

Telephone interview with the Facility Manager on 09/25/20 at 9:58am revealed:
-Resident #2 could be "combative" and/or "agitated" at times.
-Staff on 1st shift staff saw a bruise to Resident #2's wrist on the morning of 09/21/20 and did not know what happened.
-She saw the bruise to Resident #2's left wrist the morning of 09/21/20 when notified by staff.
-Resident #2 and another resident were placed in the television room by staff a the end of 3rd shift on 09/21/20.
-Resident #2 and another resident had become agitated with each other.

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D 273	Continued From page 59 -Resident #2 yelled at the other resident causing the other resident to "grab" Resident #2's arm and wrist. -Staff separated Resident #2 and the other resident. -Resident #2 developed a bruise to her left wrist. -The altercation happened on the end of 3rd shift 09/21/20. -It was expected for staff to report accident/injuries to the MA/S, an incident report completed and faxed to the PCP, the resident assessed by the MA/S to see if medical attention was needed, then notify the family/Power of Attorney. -The incident was not reported to the 3rd shift MA/S on 09/21/20. -It was expected for the MA/S to notify her or document in the MA/S communication book of the accident/injury. -When she was notified about accident/injuries she would follow up to be certain the PCP was notified. -She had not followed up to be certain Resident #2's PCP was notified about the 09/21/20 incident. -There was no process in place to assure the PCP was notified of resident accidents and/or incidents. -She expected resident behaviors to be reported to the MA/S by the end of the shift. -The PCP should be notified if a resident placed their hands on another resident resulting in injury. Telephone interview with Resident #2's MH provider on 09/28/20 at 9:18am revealed: -Resident #2 had ongoing agitation due to psychosis and dementia. -He had not been notified of Resident #2's altercation on 09/21/20 with another resident. -He expected staff to have notified him of	D 273		

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Resident #2's altercation so he could have evaluated the resident.
-Resident #2's psychiatric medications may have needed adjusting.

Telephone interview with the MA/S on 09/28/20 at 9:56am revealed:
-Sometimes Resident #2 would try to hit other residents.
-When Resident #2 would hit at other residents, staff would remove the resident from the area or verbally redirect the resident.
-Resident #2 required as needed medication for anxiety on eleven out of twenty-eight days for the month of September 2020.

Telephone interview with Resident #2's PCP on 09/28/20 at 12:00pm revealed:
-She was not notified of the altercation with Resident #2 and another resident on 09/21/20.
-She was concerned the resident could be "attacked" because she was not ambulatory.
-She expected staff to have notified her of the altercation so the resident could have been evaluated.

Review of Resident #2's facility record to include PCP correspondence revealed the resident's PCP was not notified of the 09/21/20 altercation.

Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed:
-He expected Resident #2's PCP to have been notified of the 09/21/20 altercation.
-Resident #2's PCP was available and on call 24 hours a day 7 days a week.
-He expected the PCP to have been notified by the MA/S as soon as the 09/21/20 altercation with Resident #2 occurred.
-The PCP should have been notified of resident

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aggression and/or altercations because she was the medical provider.
-The process of notification should have been staff to notify the MA/S, the MA/S to notify the Facility Manager, the Facility Manager to have notified him.
-He was not told about the 09/21/20 altercation involving Resident #2.

Telephone interview with Resident #2's Power of Attorney (POA) on 09/30/20 at 2:37pm revealed:
-The resident had a history of fighting, screaming, cursing, and hitting.
-About five or six months ago she was notified by staff the resident had gotten "mean" and wanted to "fight" residents.
-She had not been notified by the facility of altercations with other residents.
-She saw the bruise on the resident's left arm through the window of the facility on 09/23/20.
-She was notified by the PCA the bruise was caused by a previous fall from the bed.
-She expected to have been notified of Resident #2's altercation.
-She expected the residents MH provider and/or PCP to have been notified of Resident #2's altercation.

Telephone interview with Resident #2's PCP on 10/01/20 revealed she would have ordered every fifteen-minute checks on the resident until she was evaluated by MH if she had been notified of the resident's altercation.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

b. Review of Resident #2's current Care Plan dated 09/23/20 revealed the resident was under

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D 273	Continued From page 62 the care of mental health (MH). Resident #2's MH provider notes were requested on 09/28/20 but not provided. Telephone interview with Resident #2's MH provider on 09/25/20 revealed: -The resident's last MH visit was 02/03/20 during which she received medication adjustments for ongoing agitation due to psychosis and dementia. -Resident #2's Risperdal was increased from 1mg daily to 1mg twice daily. -The resident was supposed to have a follow up appointment in March 2020, but the appointment was canceled per resident request. -The appointment was never rescheduled. -He expected the appointment to have been rescheduled to evaluate the resident and medication changes. -He offered virtual visits for the facility's residents because of COVID-19. -Missing the follow up appointment could cause the resident to exhibit increased agitation, increased psychosis, and could be harmful behaviors to self or others. Telephone interview with the medication aide/supervisor (MA/S) on 09/28/20 at 9:56am revealed: -The MA/S or the Facility Manager were responsible for making follow up appointments. -Resident #2 last saw MH on 02/03/20 for agitation and aggression. -Resident #2's Risperdal was increased from 1mg daily to 1mg twice daily. -The resident was to follow up with MH two - three weeks after the February 2020 appointment. -She did not know why virtual appointments were not provided for Resident #2.	D 273		

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-The MA/S were responsible for making the virtual follow up appointment for Resident #2.
-Resident #2 was seen by her Primary Care Provider (PCP) in March 2020 for decreased ambulation.
-In March 2020, Resident #2's PCP gradually discontinued the Risperdal.
-The facility last told Resident #2's MH provider of the resident experiencing agitation in December 2019.

Telephone interview with Resident #2's PCP on 09/28/20 at 12:00pm revealed:
-She was notified by facility staff Resident #2's MH provider could no longer treat her.
-She did not know Resident #2's MH provider offered virtual visits.
-She did not know Resident #2's MH provider increased Risperdal for agitation, anxiety, and psychosis in
February 2020.
-If she had known MH was available to Resident #2 she would have consulted with the resident's MH provider to manage the medication changes instead of her adjusting them because that was his specialty.
-She discontinued Resident#2's Risperdal and other psychiatric medications in March 2020 because the resident was loosing weight.

Telephone interview with the Facility Manager on 09/29/20 at 11:00am revealed:
-The MA/S's were responsible for rescheduling Resident #2's appointments at the time the appointment was canceled.
-She expected the MA/S's to reschedule Resident #2's appointments when they were canceled.
-There was no reason to not reschedule Resident #2's appointments.
-There was no process in place to be certain

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Resident #2's appointments were kept and/or rescheduled.
-Resident #2 did not follow up with MH because she asked the facility's PCP if she could manage the psychiatric medications so they wouldn't have to take the resident to MH appointments.
-No one notified Resident #2's MH provider the facility's contracted PCP would be monitoring her psychiatric medications.
-She did not know MH was adjusting Resident #2's medications for agitation, psychosis, and anxiety.
-Resident #2's MH provider contacted the facility over the summer of 2020 offering virtual visits.

Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed:
-He did not know anything about Resident #2 missing MH appointments.
-The Facility Manager was responsible for scheduling Resident #2's appointments.
-It was not expected for Resident #2 to miss appointments.
-If Resident #2 missed an appointment it was expected the Facility Manager reschedule the appointment.

4. Review of Resident #1's current FL-2 dated 03/02/20 revealed:
-Diagnosis included dementia with Lewy bodies, Parkinson's, and schizoaffective disorder bipolar type.
-The resident was constantly disoriented, incontinent of bowel and bladder, and semi-ambulatory with a walker.
-The resident required assistance with bathing, dressing, and feeding.

Review of Resident #1's current Care Plan dated 09/23/20 revealed the resident was always

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disoriented, required limited assistance with ambulation with the use of a walker, extensive assistance with dressing, and totally dependent upon staff for toileting, eating, and grooming.

a. Review of an accident/incident report dated 09/22/20 revealed:
-Resident #1 was sitting in the television room of the Special Care Unit (SCU).
-Another resident was sitting in a wheelchair beside Resident #1.
-Staff exited the television room to assist another resident with toileting.
-Staff overheard a "commotion" in the television room.
-Staff "ran" in the television room and observed Resident #1 and another resident "hitting and slapping" at each other.
-Staff separated Resident #1 and the other resident.
-Resident #1 and the other resident continued to verbally assault each other across the room requiring staff to intervene "several times".
-The incident occurred on 09/21/20 at approximately 6:45am.
-There was no documentation Resident #1's Primary Care Provider (PCP) was informed of the accident/injury.

Interview with a personal care aide (PCA) on 09/24/20 at 12:49pm revealed:
-The facility's contracted PCP was not always notified about resident to resident incidents unless they were "real bad".
-Examples of "real bad" were biting, kicked, pushed down, or if a resident falls because they were grabbed.
-Resident #1 was ambulatory with a walker.
-She saw a note in the shift communication book where Resident #1 and another resident were in

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an altercation.
-She did not know if Resident #1's PCP was notified.

Telephone interview with the Facility Manager on 09/25/20 at 9:58am revealed:
-Resident #1 and another resident were placed in the television room by staff at the end of 3rd shift on 09/21/20.
-Resident #1 and the other resident had become agitated with each other.
-Resident #1 was hit by the other resident.
-Resident #1 grabbed the other resident's arm when she was hit.
-Staff separated Resident #1 and the other resident.
-The altercation happened on the end of 3rd shift 09/21/20.
-It was expected for staff to report accident/injuries to the medication aide/supervisor's (MA/S's), an incident report completed and faxed to the PCP, the resident assessed by the MA/S's to see if medical attention was needed, then notify the family/Power of Attorney.
-The incident was not reported to the 3rd shift MA/S on 09/21/20.
-It was expected for the MA/S's to notify her or document in the MA/S's communication book of the accident/injury.
-When she was notified about accident/injuries she would follow up to be certain the PCP was notified.
-She had not followed up to be certain Resident #1's PCP was notified about the 09/21/20 incident.
-There was no process in place to ensure the PCP was notified of resident accidents and/or incidents.
-She expected resident behaviors to be reported

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to the MA/S by the end of the shift.
-The PCP should be notified if a resident placed their hands on another resident resulting in injury.

Telephone interview with Resident #1's PCP on 09/28/20 at 12:00pm revealed:
-She was not notified about the 09/21/20 altercation with Resident #1 and another resident.
-She expected to have been notified about Resident #1's altercation with another resident because Resident #1 was ambulatory and was concerned the resident would attack the other resident.
-Resident #1 was evaluated in early September 2020 for "behavior" issues and treated for a possible urinary tract infection (infection of the tubules going to the bladder).

Review of Resident #1's facility record to include PCP correspondence revealed the resident's PCP was not notified of the 09/21/20 altercation.

Telephone interview with Resident #1's PCP on 10/01/20 revealed she would have ordered every fifteen-minute checks on the resident until she was evaluated by MH if she had been told of the resident's aggression and altercation.

Telephone interview with the PCA on 09/29/20 at 3:00pm revealed:
-Resident #1 would get agitated and yell.
-Resident #1 hit the table when another resident went to take her drink.
-She had never seen Resident #1 hit anyone.

Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed:
-He expected Resident #1's PCP to have been notified of the 09/21/20 altercation.
-The PCP was available and on call 24 hours a

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day, 7 days a week.
-He expected the PCP to have been notified by the MA/S as soon as the 09/21/20 altercation with Resident #1 occurred.
-The PCP should have been notified of resident aggression and/or altercations because she was the medical provider.
-The process of notification should have been staff to notify the MA/S, the MA/S to notify the Facility Manager, the Facility Manager to have notified him.
-He was not notified about the 09/21/20 altercation involving Resident #1.

b. Review of Resident #1's current Care Plan dated 09/23/20 revealed the resident was under the care of mental health (MH).

Resident #1's MH provider notes were requested on 09/28/20 but not provided.

Telephone interview with the medication aide/supervisor (MA/S) on 09/28/20 at 9:56am revealed:
-Resident #1 had an appointment with MH in November 2019.
-Resident #1 did not keep the appointment with MH because she could not get in the facility transportation van.
-She called Resident #1's MH provider and reported the resident could not get in the transportation van.
-She did not reschedule Resident #1's MH appointment because she didn't think the MH provider wanted to see the resident because he did not go to the facility to evaluate the resident.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/28/20 at 12:00pm revealed:

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-She had ordered Resident #1 to be evaluated by MH around November 2019 for schizophrenia, dementia, and Parkinson's disease.
-She was told MH could not see Resident #1 at the facility.
-She did not know Resident #1 did not keep the MH appointment.
-She expected to have been notified Resident #1 did not keep the MH appointment because the resident needed MH care, had a history of schizophrenia, and was on psychiatric medications.

Telephone interview with the Facility Manager on 09/29/20 at 11:00am revealed:
-She did not know Resident #1 had an appointment with MH in November 2019.
-The medication aide/supervisor's (MA/S's) were responsible for rescheduling Resident #1's appointments at the time the appointment was canceled.
-She expected the MA/S's to reschedule Resident #1's appointments when they were canceled.
-There was no reason to not reschedule Resident #1's appointments.
-There was no process in place to be certain Resident #1's appointments were kept and/or rescheduled.
-She had never followed up to ensure Resident #1 was taken to the appointments because she never felt the need to follow up.
-She asked Resident #1's PCP to manage her psychiatric medications so the resident wouldn't have to leave the facility.
-Resident #1 did not need to reschedule with MH because her PCP was managing psychiatric medications for the resident.

Telephone interview with Resident #1's family member on 09/29/20 at 2:52pm revealed:

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D 273	Continued From page 70 -The resident had a history of mental illness and was under the care of MH. -The business office manager (BOM) told her the resident's MH provider would see the resident at the facility. -The resident was prescribed psychiatric medications. Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed: -He did not know anything about Resident #1 missing appointments. -The Facility Manager was responsible for scheduling all appointments. -If a Resident #1 did miss an appointment it was expected the Facility Manager reschedule the appointment. Telephone interview with Resident #1's MH provider on 09/25/20 at 9:18am revealed he had never seen the resident. _____ The facility failed to ensure routine and acute healthcare needs were met for 4 of 4 residents, including Resident #3, who had a diagnosis of hypertension and had a history of syncope received emergent medical evaluation when the resident's blood pressure was 72/33 and oxygen saturation was 75%. The facility failed to ensure Resident #3 received emergent medical evaluation and treatment after an unwitnessed fall with head injury resulting a delay in care from the fall on 09/26/20 at 7:45pm until 09/27/20 at 8:40pm and failure to notify the primary care provider immediately. The resident required 3 sutures to the head wound at the time of treatment. The facility failed to ensure a home health referral was completed for Resident #4 who had pressure ulcers to both heels resulting in a 7 day delay in care and placed the resident at	D 273		

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D 273	Continued From page 71 risk for infection, sepsis, and death. The facility failed to notify the primary care provider of behaviors exhibited by three residents residing the special care unit that were harmful to themselves and others (#1, #2, #3, #4); failed to ensure residents went to mental health appointments and failed to coordinate mental health care services as ordered (#1, #2) resulting in continuing behaviors and a bruising injury to Resident #2's arm after an altercation with another resident. The facility's failure prevented the residents from receiving the health care services necessary to maintain their physical and mental health, resulting in serious neglect constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 29, 2020 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2020.	D 273		
D 293	10A NCAC 13F .0904(c)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Home: (4) Menus shall be planned to take into account the food preferences and customs of the residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to plan and serve menus that accommodated the residents' preferences and considered the residents' likes and dislikes.	D 293		

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D 293	Continued From page 72 The findings are: Interview with 3 residents on 09/24/20 at 10:39am revealed: -They had not been provided a meal substitution when they requested it. -The cook and the medication aide/ supervisor (MA/S) would tell them no. -The Facility Manager and a MA/S had told them it was against state regulations to substitute meals. -They had been told by the cook that they needed to eat what was on their plate and if they did not like it then they needed to leave it on the plate. Interview with a MA/S on 09/24/20 at 1:06pm revealed: -She had heard the cook tell residents that they could not substitute anything the resident was served during meal times. -There are only 2 employees that work in the kitchen at the facility -One cook works for 4 days, then the next cook comes on and works for 4 days. -She had told residents that they could not substitute anything the resident was served during meal times. -Resident's could get a sandwich as a replacement. -The cooks would not go out of their way to fry something for the resident as a substitution. -If a resident had requested a meal substitute, the MA/SIC would notify the Primary Care Physician (PCP) to get a doctor's order to serve the resident something else. -She had not remembered how long she had been contacting the PCP to get orders to substitute a meal for a resident. -When one resident had not liked something, all	D 293		

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the other residents had complained that did not like the same food.
-She had told residents that had requested a meal substitute that it was against state regulations to substitute.
-One of the cooks that had worked at the facility many years ago had told her that it was against state regulations to substitute meals.
-She had not read the state regulations about food and nutrition.

Interview with the cook on 09/24/20 at 1:41pm revealed:
-She had worked at the facility for 9 years.
-She had never refused to substitute a meal for a resident.
-She would write what was to be served for meals several hours before the meal time.
-She would go around and ask residents on the assisted living 30 to 40 minutes before meal time if they wanted what was going to be served or ask if they had wanted a substitution.
-She had not known why residents had said that they could not substitute their meals.
-She had never heard residents complain that they could not substitute their meals.
-If she noticed a resident not eating, she would ask the resident if they would like something else to eat.

Interview with the Facility Manager on 09/24/20 at 4:45pm revealed:
-Residents are supposed to be given a meal substitution if they requested it.
-She expected staff to provide a meal substitution to residents when they requested.
-Residents had been provided sandwiches in the past when they had requested a substitution.
-She did know know of any staff telling residents that it was against state regulations to substitute

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D 293	Continued From page 74 a meal.	D 293		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, observations, and record reviews the facility failed to ensure transportation was available to transport residents to medical appointments resulting in 2 of 2 sampled residents (#1,#3) not having transportation to the hospital and medical appointments. The findings are: Observation on 09/24/20 at 12:00pm revealed there was one van parked in the parking area on the right side behind the facility. 1. Review of Resident #3's current FL-2 dated 10/20/19 revealed diagnoses included	D 321		

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D 321	Continued From page 75 Alzheimer's, dementia psychosis, lymphoid leukemia, hyperlipidemia, insomnia, hypertension, gastroesophageal reflux disease, and hypokalemia. a. Review of an emergency room (ER) provider note for Resident #1 dated 05/02/20 revealed: -Resident #3 had been sent to the ER on 05/02/20 at 5:17pm, with a complaint of mouth lesions and a low-grade temperature of 100.7 degrees Fahrenheit. -Resident #3 was discharged back to the facility on 05/02/20. Review of a handwritten referral and appointment correspondence for Resident #3 to an oral and maxillofacial surgeon dated 05/02/20 revealed: -Resident #3's dentist had been unable to perform a full exam on 05/02/20 because Resident #3 had been unwillingly to allow the dentist to look in her mouth. -Resident #3's dentist had referred the resident to an oral and maxillofacial surgeon. -Resident #3 had an appointment scheduled with the oral and maxillofacial surgeon on 06/08/20 at 3:30pm. -Resident #3's dentist had signed the referral and appointment correspondence. Telephone interview with the Patient Care Coordinator at the oral and maxillofacial surgeon's office on 09/28/20 at 12:03pm revealed: -Resident #3 had been a no call no show for her appointment on 06/08/20 at 3:30pm. -A no call, no show meant that the office had not received a call that Resident #3 would not be attending the appointment and she had not shown up to the appointment. -The missed appointment had not been	D 321		

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rescheduled.

Interview with Resident #3's PCP on 09/28/20 at 12:56pm revealed:
-Resident #3 had poor dental hygiene.
-She had been aware that Resident #3 had went to the dentist on 05/02/20.
-Poor dental health leads to myocarditis (an inflammation of the heart muscle), endocarditis (an infection of the the inner lining of your heart chambers and heart valves), and potentially death.
-Resident #3 had a high risk of the infection reoccurring by missing her appointment with the oral and maxillofacial surgeon.

Interview with a medication aide/supervisor (MA/S) on 09/29/20 at 9:52am revealed:
-The facility did not provide transportation for the residents all the time.
-Residents' families are responsible for transporting residents to appointments.
-The Activities Director and the housekeeper would sometimes transport residents to appointments.
-If family had refused to transport the resident to an appointment, then the facility would transport the resident.

Interview with Resident #3's family member on 09/30/20 at 3:24pm revealed:
-He transported the resident to her medical appointments outside of the facility.
-He had taken Resident #3 to her dentist appointment on 05/02/20.
-Resident #3 had not let the dentist look in her mouth.
-Resident #3's dentist had referred her to oral and maxillofacial surgeon.
-He had been provided a phone number to call to

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schedule the appointment by Resident #3's dentist office.
-Resident #3's dentist gave him the residents discharge paperwork, that he gave to the facility when he returned the resident back to the facility.
-The facility had not coordinated transportation to the appointment for Resident #1 and he had not been made aware that Resident #3 had an appointment on 06/08/20 at 3:30pm at an oral and maxillofacial surgeon's office and needed transportation.

Telephone interview with the BOM on 09/30/20 at 3:52pm revealed the facility did not provide transportation to the residents and the resident's family was responsible for providing transportation.

Telephone interview with the Facility Manager on 09/29/20 at 10:15am revealed Resident #3 family had been responsible for transporting her to medical appointments.

Attempted interview with Resident #3's dentist on 10/01/20 at 1:05pm was unsuccessful.

Refer to telephone interview with the Facility Manager on 09/29/20 at 10:00am.

Refer to telephone interview with a nursing assistant (NA) on 09/29/20 at 3:00pm.

Refer to telephone interview with the Business Office Manager (BOM) on 09/30/20 at 3:46pm.

Refer to the telephone interview with the Administrator on 09/30/20 at 4:00pm.

b. Telephone interview with Resident #3's family member on 09/30/20 at 3:24pm revealed:

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D 321	Continued From page 78 -When the resident was admitted to the facility, the Business Office Manager (BOM) told the family the facility was short staffed and did not have staff available to transport the resident to appointments. -The family member "signed" approval that family would transport the resident to her appointments. -The family member transported Resident #3 to her appointments. -He received a call from a medication aide/supervisor (MA/S) on 09/26/20 around 7:45pm that Resident #3 had fallen. -The MA/S told the family member that the resident had a small cut to her head, and he was asked did he want Resident #3 to go to the Emergency Room (ER). -He had refused to send Resident #3 to the ER, because it was only a small cut. -Another family member visited Resident #3 on 09/27/20 at the facility and that family member reported to him that Resident #3 had a large wound to her forehead. -He went to the facility on 09/27/20 to visit Resident #3 and examine the wound. -On 09/27/20, he had discovered the wound was larger than what was reported to him by the MA/S. -He requested MA/S on duty transport the resident to the ER. -The MA/S called the Facility Manager to speak with the family member. -The Facility Manager told the family member that he would have to transport the resident to the ER because the facility did not have enough staff to transport the resident to the ER and the request was not an emergency. -He had transported Resident #3 to the ER. -Resident #3 had received three stitches to the wound on her head.	D 321		

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Telephone interview with the BOM on 09/30/20 at 3:52pm revealed the facility did not provide transportation to the residents and the resident's family was responsible for providing transportation.

Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed:
-He did not know the BOM told Resident #3's family member the family would need to transport the resident to her medical appointments.
-Family members had been told it was "preferred" that the family transport residents to appointments but if the family could not transport, the facility would transport the resident.

Refer to telephone interview with the Facility Manager on 09/29/20 at 10:00am.

Refer to telephone interview with a nursing assistant (NA) on 09/29/20 at 3:00pm.

Refer to telephone interview with the Business Office Manager (BOM) on 09/30/20 at 3:46pm.

Refer to the telephone interview with the Administrator on 09/30/20 at 4:00pm.

2. Review of Resident #1's current FL-2 dated 03/02/20 revealed:
-Diagnosis included dementia with Lewy bodies, Parkinson's disease, schizoaffective disorder bipolar type.
-The resident was constantly disoriented, semi-ambulatory with a walker, incontinent of bowel and bladder, and required assistance with dressing, feeding, and bathing.

Telephone interview with a medication

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aide/supervisor (MA/S) on 09/28/20 at 9:56am revealed:
-Resident #1 missed a mental health appointment in November 2019 because she could not get in the facility's transportation van.
-She did not call for mobile transport to provide transportation for the resident.
-Resident #1's appointment with mental health had not been rescheduled after the missed appointment in November 2019.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/28/20 at 12:00pm revealed:
-She had ordered Resident #1 to follow up with mental health in November 2019.
-Resident #1 needed to follow up with mental health because she had schizophrenia, Parkinson's and dementia, and was on psychiatric medications.
-She did not know Resident #1 could not get in the facility's transport van and had missed the mental health appointment.
-The facility could have called a mobile transport company to transport Resident #1 to the mental health provider's office.

Telephone interview with Resident #1's family member on 09/29/20 at 2:52pm revealed:
-The resident had a history of mental health illness.
-When the resident was first admitted, the Business Office Manager (BOM) told her it was the family's responsibility to transport residents to medical appointments.
-She told the BOM it was not possible for her to transport the resident to medical appointments because she did not live locally.
-She was not asked to transport Resident #1 to appointments afterwards.

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D 321	Continued From page 81 -She did not know the resident could not get into the facility's transportation van. -She expected the facility to have made other arrangements to be certain the resident was taken to mental health appointments. Telephone interview with the Facility Manager on 09/29/20 at 11:00am revealed: -She did not know Resident #1 had missed an appointment with mental health November 2019. -She knew Resident #1 could not get in the facility's transportation van. Telephone interview with Resident #1's mental health provider on 09/25/20 at 9:18am revealed he had never seen the resident. Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed: -He did not know anything about residents missing appointments. -The Facility Manager was responsible for scheduling all appointment and coordination transportation for residents to their appointments. -The facility has had or about one year now, a vehicle with a wheelchair lift to transport residents to appointments. Telephone interview with the Facility Manager on 10/01/20 at 10:55am revealed: -The Administrator was confused about the facility having a wheelchair accessible van; the facility did not have a wheelchair accessible van. -The facility did not have another means of providing transportation for Resident #1 to her mental health appointment. Refer to telephone interview with the Facility Manager on 09/29/20 at 10:00am.	D 321		

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D 321	Continued From page 82 Refer to telephone interview with a nursing assistant (NA) on 09/29/20 at 3:00pm. Refer to telephone interview with the Business Office Manager (BOM) on 09/30/20 at 3:46pm. Refer to the telephone interview with the Administrator on 09/30/20 at 4:00pm _____ Telephone interview with the Facility Manager on 09/29/20 at 10:00am revealed: -Residents' family members were responsible for transporting residents to their provider appointments. -If family would not provide transportation and staff could not get the resident into the facility's transportation van, it would be the family's responsibility and expense to provide transportation for the resident. -She did not know it was the facility's responsibility to provide transportation for resident appointments. -The facility had provided transportation for residents when family members were not able to transport the residents. Telephone interview with a nursing assistant (NA) on 09/29/20 at 3:00pm revealed: -She had heard through out the facility that family members were responsible for transporting residents to medical appointments. -A resident's family member told her in the past she could not provide the resident with transportation to medical appointments. -The family member wanted to know who she could talk with about not being able to provide transportation to medical appointments. -She could not remember when the family member told her this. -She had transported residents to medical	D 321		

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appointments in the past.
-She did not know who was responsible to transport residents to medical appointments.

Telephone interview with the BOM on 09/30/20 at 3:46pm revealed:
-The facility stopped providing transportation for residents to medical appointments when the facility began using a contracted Primary Care Provider (PCP) who came to the facility (no date provided).
-Residents' family members were told they would be responsible for providing transportation to provider appointments.
-Residents' family members agreed to provide resident transportation for provider appointments.
-If a resident could not get into the facility's transportation van, and the family could not provide transportation, the facility could contact a mobile transport company for transportation to the provider appointment.
-She did not know if the facility had ever had a situation when a resident could not get in the facility's transportation van.

Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed:
-Staff should not tell residents and/or family members that the families were responsible for transporting residents to provider appointments.
-Private pay residents were told it was "preferred" their family members provided transportation for provider appointments.
-The facility would provide transportation for residents to medical appointments if their family members could not.
-The facility transported residents to appointments "99%" of the time.
-The facility had 2 vehicles including a wheel chair accessible van to transport residents.

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D 321	Continued From page 84 -The Facility Manager was responsible for scheduling residents' medical appointments and coordinating transportation to the appointments. _____ The facility failed to establish a system to coordinate and ensure the provision of transportation to residents to medical appointments resulting in a missed mental health appointment for Resident #1 who could not get into the facility's van because it was not wheelchair accessible. The resident required psychiatric medications for diagnoses including schizophrenia and dementia; the mental health appointment was never rescheduled The facility failed to coordinate transportation to an oral surgeon's office for Resident #1 after the resident was referred by her dentist for further evaluation of swelling in her jaw and a low grade temperature. The resident was a no call, no show to the oral surgeon's appointment, placing the resident at increased risk of infection. The facility refused to transport Resident #3 to the hospital for medical evaluation after a fall resulting in the resident's family member transporting the resident. The facility's failure resulted in residents not being provided with the provision of transportation to medical appointments and the hospital which was detrimental to the health and safety of the residents and constitutes a TYPE B VIOLATION. The facility provided a plan of protection in accordance with G.S. 131D-34 on October 1, 2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2020.	D 321		

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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.

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

Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to failure to notify their local health department (LHD) for a resident who tested positive for COVID-19; screening of visitors; use of personal protective equipment (PPE) by staff and residents; practicing social distancing amongst residents; infection control procedures related to maintaining environmental cleanliness and use environmental protection agency (EPA) approved disinfectants to reduce the risk of transmission and infection with the deadly virus.

The findings are:

Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease (COVID-19) in long term care facilities revealed:
-Personnel should always wear a face mask in the facility.
-Face masks should not be worn under the nose

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or mouth.
-All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.
-Personnel should be screened for fever and symptoms of COVID-19 before starting each shift.
-Screen residents daily for fever and symptoms of COVID-19.
-All personnel should practice social distancing (remain at least six feet apart) when in common areas.
-Implement social distancing among residents.
-If COVID-19 is identified in the facility, restrict all residents to their rooms.
-Residents with known or suspected COVID-19 should be cared for using recommended PPE including use of eye protection, gloves, gown, and N95 respirator face mask or face mask if a N-95 mask is not available.

Review of the CDC Considerations for Memory Care Units in Long-term Care Facilities revealed:
-Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated).
-Cloth face coverings should not be used for anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
-Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are near other residents or personnel.

1. Review of an Emergency Room (ER) provider

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note dated 08/03/20 revealed:
-A resident was admitted to the ER and tested positive for COVID-19.
-The resident was discharged back to the facility on 08/04/20.

Interview with a medication aide/supervisor (MA/S) on 09/24/20 at 11:23 am revealed:
-One month ago, a resident tested positive for COVID-19.
-She did not remember the exact date.
-The facility was notified by the local hospital that the resident was positive for COVID-19.
-The resident was quarantined for 14 days when she returned to the facility until the repeat COVID-19 test was negative.
-She did not know if the local health department (LHD) had been notified.

Telephone interview with the facility Manager on 09/25/20 at 1:23pm revealed:
-She had reviewed CDC guidance on COVID-19.
-She did not remember the last time she reviewed CDC guidance on COVID-19.
-There was a resident in the special care unit (SCU) that tested positive for COVID-19 in August 2020.
-She did not remember the exact date.
-She notified the resident's primary care provider(PCP) that the resident was positive for COVID-19.
-She was told she did not have to report the one positive case of COVID-19 to the LHD.
-She had been told that she only had to report two or more positive cases of COVID-19 to the LHD.
-She did not remember when or who told her that she did not have to report 1 positive case of COVID-19 to the LHD.
-She did not report the positive COVID-19

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resident to the LHD.

Telephone interview with the Clinical Nursing Supervisor (CNS) at the LHD on 09/25/20 at 3:59pm revealed:
-She and the LHD staff had not been notified by the facility that there had been a resident positive with COVID-19 at the facility in August 2020.
-She expected to be notified that the resident was positive for COVID-19 so the LHD could keep track of all positive cases.
-She did not know who told the facility Manager that she did not have to report one positive case of COVID-19 to the LHD.
-The facility was responsible for reporting any residents that were positive with COVID-19 to the LHD.
-She had not talked to the facility Manager or the Administrator of the facility about COVID-19.
-The facility Manager called her on 09/17/20 and left a voicemail.
-She did not know why the facility Manager called her.
-She was out of the office and did not get the voicemail from the facility Manager until 09/24/20.
-She called the facility Manager back on 09/24/20 but she was unavailable.
-She left a message with staff at the facility for the facility Manager to call her back.

A second telephone interview with the CNS of the LHD on 09/28/20 at 2:36pm revealed:
-It was not acceptable for the facility to not notify the LHD that a resident in the facility tested positive for COVID-19.
-It was expected the facility notify the LHD that a resident in the facility tested positive for COVID-19 so the LHD could have provided guidance and education to the facility regarding infection control measures and NCDHHS

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guidelines.
-The facility manager did not include in the 09/17/20 voice mail what the call was about.
-She still had not spoken with the Facility Manager as of today, 09/28/20.

Telephone interview with the Administrator on 09/30/20 4:01pm revealed:
-He was aware that there was a resident in the SCU that had tested positive for COVID-19 in August 2020.
-The resident was placed on quarantine for 14 days in the facility after a diagnosis and return from the hospital.
-He did not contact the LHD to notify the resident was positive for COVID-19.
-He did not think anyone in the facility had notified the LHD.
-He did not know he was required to notify the LHD about the resident that had been positive with COVID-19.
-He did not contact the LHD to discuss COVID-19 guidelines.

Refer to telephone interview with the Facility Manager on 09/25/20 at 10:38am.

2. Observations on 09/24/20 at 10:06am revealed:
-There was a basket propped on a handrail to the right on the inside of the facility entrance door.
-There were two oral digital thermometers, two pencils, and a bottle of hand sanitizer in the basket.
-The thermometers were not covered or protected from the environment.
-The medication aide/supervisor (MA/S) removed the thermometer with an ear probe from the basket and placed the ear probe thermometer in front of the first surveyor's forehead to scan for a

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temperature. The temperature reading was 93.5.
-The MA/S placed the same ear probe thermometer in front of the second surveyor's forehead to scan for a temperature. The temperature reading was 95.4 Fahrenheit (F).

Review of the thermometer used to assess the surveyors' temperatures on 09/24/20 at 10:10am revealed:
-On the side of the thermometer was documentation which read "ear and forehead thermometer".
-One end of the thermometer was a cylinder-shaped tip with the picture of an ear directly below.
-The opposite end of the thermometer was a circular concave shaped end with a picture of a head directly below.
-Located in the middle of the thermometer was a liquid crystal display (LCD) screen.

Review of an instruction manual for the facility's ear and forehead thermometer revealed:
-The cylinder-shaped tip was the ear probe.
-The circular concave shape was the light/fever indicator.
-There was a forehead adapter with a flat end that was to be placed over the ear probe.
-To assess a forehead temperature the forehead adapter was to be applied before use.
-Place the thermometer with the forehead adapter flush on the center of the forehead.
-Once the thermometer is touching the forehead hold the thermometer steady and press the head symbol to start the measurement.
-Keep the thermometer flat until a beep is heard.

Review of a document titled "Staff Screening Form" revealed:
-There were four staff temperatures assessed at

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D 338	Continued From page 91 7:00am on 09/24/20. -The documented temperatures were: 95.9 F, 94.5 F, 97.5 F, and 94.1 F. Interview with the MA/S on 09/24/20 at 10:07am revealed: -The facility had two different thermometers: a dual ear/forehead thermometer and a forehead thermometer. -The thermometer used to assess surveyor temperatures this morning, 09/24/20, was the dual ear/forehead thermometer that could read a temperature through the forehead or ear. -One end of the thermometer was designated as an ear thermometer and the opposite end was designated as a forehead thermometer. -She used the ear probe this morning, 09/24/20, to assess the temperatures of residents, self, and surveyors. -She had not been trained on how to use the thermometer. -She had previously just read the instructions for the thermometer and that was her only training. -The instruction manual stated to place the "head" end to the forehead to assess temperatures. -The head end was the circular concave end of the thermometer. -She worked about six days a week and had always used the ear probe of the thermometer to check temperatures through the forehead for visitors, residents, and staff since March 2020. -She was not comfortable using the forehead probe because she could never get it to assess the temperatures. -Staff performed self-temperature assessments upon their entrance to the facility this morning, 09/24/20. -She used the ear probe to scan her forehead temperature this morning, 09/24/20.	D 338		

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D 338	Continued From page 92 -COVID-19 screening questions were provided for staff and visitors on entrance to the facility. A second interview with the MA/S on 09/24/20 at 12:00pm revealed: -She did not know if the facility had a COVID-19 policy. -Residents were not screened for COVID-19. -She had never heard of screening residents for COVID-19 at the facility. Telephone interviews with the facility's contracted Primary Care Provider (PCP) on 09/28/20 at 12:00pm and 12:50pm revealed: -She expected staff to use a digital forehead thermometer to assess temperatures of residents, staff and visitors because it was more accurate than scanning the forehead with an ear probe. -She did not know staff was using the ear probe to check for temperatures through the forehead. -An ear probe was to be placed in the ear with a cover to assess a tympanic temperature not scanned over the forehead because the readings would not be accurate. -Staff had never assessed her temperature upon her entering the facility. -Staff had never asked if she had self-assessed her temperature and/or what her temperature was on entrance to the facility. -She expected staff to ask what her temperature was on entrance to the facility. -She had not told staff her temperature. -She did not know residents were not being screened for COVID-19. -Staff had never performed COVID-19 screening on her entrances to the facility. -She expected staff to perform COVID-19 screening on residents and visitors to help identify anyone with COVID-19 signs and/or symptoms.	D 338		

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D 338	Continued From page 93 -She did not indicate if she had informed the Administrator that staff had not been screening her upon entry into the facility. -In early March 2020 she spoke with the MA/S regarding the importance of protecting residents from COVID-19 by screening and assessing temperatures of residents, staff, and visitors. Telephone interview with the Facility Manager on 09/25/20 at 1:23pm revealed: -She was not aware that staff were using the ear and forehead thermometer to check for temperatures through the forehead. -There was a forehead thermometer available for staff to use. -She expected staff to assess temperatures of staff, residents, and visitors by using the forehead thermometer. -She did not know where staff had gotten the tympanic thermometer from. Telephone interview with a Clinical Nurse Supervisor (CNS) of the local health department (LHD) on 09/28/20 at 2:36pm revealed: -The facility was expected to assess the temperature of every visitor to the facility. -The facility was expected to use the ear probe thermometer to scan foreheads when assessing temperatures because the results would not be accurate. -She expected the facility to use the forehead thermometer for assessing temperatures. -If the facility used the ear probe to assess temperatures, it was expected to use a probe cover and assess in the ear for an accurate temperature. -She expected the facility to perform COVID-19 screening for every resident and visitor to detect signs and/or symptoms of COVID-19.	D 338		

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Telephone interview with the Administrator on 09/30/20 4:01pm revealed:
-He did not know staff had been using the ear thermometer to check for temperatures through the forehead.
-He expected staff to check temperatures through the forehead with a forehead thermometer.

Refer to telephone interview with the facility Manager on 09/25/20 at 10:38am.

3. Observation and interview of a nursing assistant (NA) on 09/24/20 at 10:50am revealed:
-The NA was wearing a disposable mask below the nose.
-The NA pulled the disposable face mask up over the nose.
-The mask would slip below the nose.
-Staff were supposed to wear face masks over the nose and below the chin.

Observation of the supply of face masks on 09/24/20 located in the SCU revealed there were three face masks located in the nurses station.

Observation of the MA/S on 09/24/20 at 11:30am revealed:
-She was in the MA/S office wearing a cloth face mask below her nose.
-She walked into the assisted living (AL) halls wearing the cloth face mask below her nose and returned to the MA/S office with the face mask below her nose.
-She was prompted to reposition the face mask above her nose.

Interview with the MA/S on 09/24/20 at 11:35am revealed:
-Face masks were supposed to be worn over the

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nose and under the chin.
-The face mask would slip below her nose.

A second observation and interview of the NA on 09/24/20 at 12:48pm revealed:
-The NA was wearing a disposable face mask below the nose.
-The NA repositioned the face mask after being prompted.
-The facility had additional face masks if a new face mask was needed.
-The MA/S would provide additional face masks if needed.

Telephone interview with the facility Manager on 09/25/20 at 10:38am revealed:
-Staff were expected to wear face masks above the nose and below the chin.
-She educated staff two weeks ago about the need to wear face masks above the nose and below the chin.

Telephone interview with the facility's contracted primary care provider (PCP) on 09/28/20 at 12:00pm revealed:
-It was not acceptable for staff to wear a face mask below the nose.
-She expected staff to wear a face mask over the nose and below the chin to decrease the spread of COVID-19.
-In early March 2020, she had educated the MA/S regarding the importance of protecting residents from COVID-19 by staff wearing face masks.

Telephone interview with a Clinical Nurse Supervisor (CNS) with the local health department (LHD) on 09/28/20 at 2:36pm revealed staff were expected to wear a face mask above the nose and below the chin to decrease the spread of COVID-19.

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D 338	Continued From page 96 Refer to telephone interview with the Facility Manager on 09/25/20 at 10:38am. 4. Interview with a MA/S on 09/24/20 at 11:23am revealed: -She had taken the hand sanitizer away from residents because the residents were using it too much. -She told the residents on the Assisted Living (AL) side to use soap and water when she took the hand sanitizer from the residents. -She did not remember when the hand sanitizer was available to residents or when she had taken it away. -She did not discuss removing the hand sanitizer from resident access with the facility manager or the Administrator. -The personal care aides (PCAs) and MA/Ss were responsible for refilling resident soap dispensers in the facility. -She did not know if the contents in the soap dispensers that the residents used was anti-bacterial. Observation of the common resident bathroom on the AL side revealed: -There was a 7.5 ounce (oz) clear soap container with a label "antibacterial hand soap". -The label was torn and faded. -The container was approximately 90% full of pink liquid. A second interview with the MA/S on 09/24/20 at 11:25am revealed: -The soap container in the common residents' bathroom did not contain the original hand soap. -The soap container had been refilled by the housekeeper. -She did not know if the refilled hand soap was an	D 338		

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antibacterial hand soap.
-She would need to look at the original container on the housekeepers cleaning cart.

Review of a container identified by the MA/S as contents used for refilling soap dispensers revealed:
-It was a 1-gallon clear container with pink liquid that was 75% full.
-The container was labeled by the manufacturer as "Pink Dish Detergent".
-The dish detergent was not an antibacterial detergent.
-There was no label that indicated that the contents were anti-bacterial.
-There was a precautionary statement that documented "Prevention: Wash hands thoroughly after handling".
-The dish detergent was for dishwashing only.
-There was no Environmental Protection Association (EPA) identification number listed on the container.

Telephone interview with the Facility Manager on 09/25/20 from at 1:23pm revealed:
-She did not know that the MA/S had taken the hand sanitizer away from residents' access.
-She expected hand sanitizer to be available for residents' use whenever they wanted to use it.
-She was responsible for buying soap for the facility.
-She would try to purchase supplies once a month for the facility.
-She was not always able to find anti-bacterial soap or hand sanitizer.
-She would buy what she could find.
-It was the responsibility of the MA/S to notify her when supplies were low.
-The MA/S's would make a weekly list of supplies needed.

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-She did not remembered the last time she had bought hand sanitizer or antibacterial soap.
-She did not indicate if she had walked through the facility to ensure residents' had antibacterial soap and hand sanitizer accessible.
-She did not know staff was filling the residents' soap dispensers with dish detergent that was only to be used for dish washing.
-She had only been able to locate one bottle of antibacterial soap in the facility today, 09/25/20.

Refer to telephone interview with the Facility Manager on 09/25/20 at 10:38am.

5. Interview with a housekeeper on 09/24/20 at 10:51am revealed:
-He worked Monday through Saturday, from 7:00am to 3:00pm.
-The MA/S had provided him with COVID-19 training in March 2020 which was to wear a face mask, have his temperature checked, and hand washing.
-He sanitized and disinfected the floors, bathrooms, showers, and resident rooms daily.
-He sanitized and disinfected the door knobs and railings every other day.
-The facility provided him with cleaning supplies.
-He did not know if any of the cleaning supplies were Environmental Protection Association (EPA) approved.
-He did not know about the CDC guidelines for EPA disinfectants.
-He had not changed his cleaning or disinfecting schedule or practices since the COVID-19 pandemic started.
-He had not received education from the facility on what cleaners were effective against COVID-19.

A second interview with the housekeeper on

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09/24/20 at 11:25am revealed:
-He was told by the MA/S to wipe down the door knobs and hand rails every other day.
-He cleaned the rails, rooms, knobs, bathrooms, and floors in the SCU once daily.

Review of a manufacturer's label on a container identified by the housekeeper as contents used for sanitizing and disinfecting door knobs and railings revealed:
-The contents were used to clean, disinfect, and deodorize.
-The active ingredient was "thymol" (Thymol, is an ingredient derived from common culinary herbs like thyme and others and is known for its antimicrobial properties).
-There was documentation the cleaner killed 99.9% of household germs.
-COVID-19 was not listed as one of the germs killed by the cleaner.
-There was no EPA identification number listed on the container.

Interview with a nursing assistant (NA) on 09/24/20 at 11:10am revealed:
-The housekeeper would clean the SCU one time a day.
-The housekeeper would not clean the door knobs or hand rails of the SCU.
-The SCU door knobs and hand rails were not cleaned throughout the day.

Interview with a MA/S on 09/24/20 11:23am revealed:
-The housekeeper was supposed to sanitize floors, bathrooms, door knobs, and common areas once a day, Monday through Saturday.
-MA/Ss and personal care aides (PCAs) used cleaning supplies from the housekeeper's cart to clean the bathrooms and floors on Sunday's.

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D 338	Continued From page 100 -MA/Ss and PCAs did not clean door knobs on the weekends. Refer to telephone interview with the Facility Manager on 09/25/20 at 10:38am. 6. Observation of the outside of the facility on 09/24/20 at 10:04am revealed 3 residents were sitting along the porch not wearing face masks. Observations of the assisted living (AL) side of the facility on 09/24/20 from 10:19am - 10:33am revealed: -There were two residents ambulating the hallways by the medication aide/supervisor (MA/S) office not wearing face masks. -One of the residents walked into a resident room where two other residents were sitting. -None of the three residents in the room were wearing face masks. -The residents in the room were not social distancing. -Staff did not redirect the residents who had not been social distancing. Interview with a resident on the AL side on 09/24/20 at 10:19am revealed: -Residents were not required to wear face masks in the facility. -Residents were not required to social distancing in the facility. Interview with a second resident on the AL side on 09/24/20 at 10:26am revealed: -Residents were not required to wear face masks in the facility. -Residents were not required to social distance in the facility. -Staff did not prompt residents to wear face masks or social distance in the facility.	D 338		

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D 338	Continued From page 101 Interview with a third resident on the AL side on 09/24/20 at 10:30am revealed: -Residents were not required to wear face masks in the facility. -Residents were not required to wear a face mask in the transportation van. -Residents were required to put on a face mask before entering a healthcare provider's office. -Residents could remove their face mask when exiting the provider's office before entering the transportation van. -Residents were only required to social distance with meals in the dining room. -Residents were not required to social distance with activities. Interview with a fourth resident on the AL side on 09/24/20 at 10:39am revealed: -Staff had given her a mask. -She did not remember when she had received the mask. -Beginning a month ago, residents did not have to wear a mask in the building. -Residents only had to wear a mask when they went to an outside doctor's appointment. -The Facility Manager told all the resident that they were no longer required to wear a mask about a month ago. -The Facility Manager said that no one in the facility was COVID-19 positive so the residents did not have to wear a mask. Interview with a cook on 09/24/20 at 10:30am revealed: -Residents had began to wear face masks 4 months ago. -Residents were issued face masks by the facility. -She did not remember when the residents were no longer required to wear masks.	D 338		

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D 338	Continued From page 102 -Staff always had to wear a face mask during their shift. -She used her own face mask, but the facility had face masks available for staff to use. Observation of the special care unit (SCU) on 09/24/20 at 10:40am revealed: -There were eight residents sitting in the common living room. -There was a nursing assistant (NA) sitting in the doorway of the common living room. -The eight residents were not social distancing. -The eight residents were not wearing face masks. -The NA did not prompt residents to social distance or wear a face mask. Interview with the NA on 09/24/20 at 10:50am revealed: -Residents were not wearing masks or social distancing today, 09/24/20. -She did not know why residents were not social distancing today, 09/24/20. Interview with a second NA on 09/24/20 at 10:55am revealed: -There were 11 residents in the SCU. -Residents were not required to social distance because there was not a positive COVID-19 case in the SCU. -Residents participated in communal dining. -Staff did not prompt residents to social distance. -If there was a positive COVID-19 case in the SCU, the residents would social distance. -If there was a positive COVID-19 case in the SCU, staff would prompt residents to social distance. -The only time SCU residents were required to social distance was in August 2020 when a resident in the SCU had a positive diagnosis of	D 338		

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D 338	Continued From page 103 COVID-19. -The MA/S told staff at that time that SCU residents were supposed to social distance. -The SCU residents did not have social distance after that one resident's COVID-19 test was negative. Observation of the SCU dining room on 09/24/20 at 11:00am revealed: -There were two rectangular tables that measured 8 feet long by 3 feet wide. -There were 4 chairs at the first table. -There were 5 chairs at the second table. -There was a round table that measured approximately 3 feet in diameter. A second interview with the second NA on 09/24/20 and observation at 11:10am revealed: -All 11 residents sat in the dining room at the same time. -There were 6 residents that sat at the first table not utilizing social distancing. -Two of those residents sat at the table in their wheelchairs. -The other 4 sat in dining room chairs. -There were 5 residents that sat at the second table. -The round table was where staff would sit not utilizing social distancing. -Resident meals were not staggered to allow for social distancing. -Residents did not social distance during meals. Interview with the housekeeper on 09/24/20 at 10:51am revealed residents were not required to wear face mask unless they went to an outside doctor's appointment. Interview with the MA/S on 09/24/20 at 11:23am revealed:	D 338		

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-About one month ago, the residents stopped wearing face masks in the facility.
-At that time, the Facility Manager told residents that they were no longer required to wear facemask.
-Residents in the SCU would not keep on the face masks.
-Residents were expected to wear face masks in the van when leaving the facility.
-Staff would provide residents with a face mask to apply before leaving the facility.
-Some of the residents would remove their face mask when leaving provider appointments.
-It was "okay" for the residents not to wear their face mask in the van because that was their choice.
-The residents were not supposed to remove their face mask until returning to the facility. She did not know why.
-Residents should not "get in each other's face" because of possible COVID-19 germs.
-The Facility Manager told residents it was their choice to wear a mask while in the building.
-The Facility Manager told the MA/S that she had told residents that they were no longer required to wear a mask.
-She did not remember when the Facility Manager told residents about the face mask.
-Residents were social distancing in the dining room during meals only.
-Meal on the assisted living had been separated into two different meal times for breakfast, lunch, dinner.
-Half of the resident would go to lunch first, and the other half would go after the first half was done and she would to sanitize the dining room after each set of residents' had finished their meals.
-There were 2 residents to a table, and they were seated 6 feet apart in order to allow for social

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distancing.
-Residents in the SCU were supposed to social distance but could not because of their diagnoses.
-Staff were expected to prompt residents in the SCU to social distance.
-It was the residents' choice to wear a face mask or not.
-She did not tell SCU staff that residents were not required to social distance.
-She did know the CDC guidance.

Telephone interview with the Facility Manager on 09/24/20 at 4:45pm revealed:
-Face masks were required for residents in August 2020 when a resident returned from the hospital positive for COVID-19.
-Residents were no longer required to wear a face mask after the positive resident tested negative.
-She thought residents did not have to wear masks if they did not have any residents positive with COVID-19 in the facility.
-She had not reached out to the LHD for guidance.
-She did not know the CDC guidance.
-She had not last shared COVID-19 information with her staff sometime in August.

Telephone interview with the Facility Manager on 09/25/20 at 10:38am revealed:
-She did not know what the CDC guidelines were regarding residents and face masks.
-She knew residents were supposed to utilize social distancing.
-She had not received any guidance from the Administrator regarding the expectation for residents and COVID-19.
-She initiated social distancing and face masks for all residents about two months ago when a

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resident had tested positive for COVID-19.
-She stopped social distancing and use of face masks for all residents after the one resident tested negative for COVID-19.

Telephone interview with the facility's contracted primary care provider (PCP) on 09/28/20 at 12:00pm revealed:
-Residents in the SCU did not practice social distancing.
-She expected staff to prompt residents in the SCU to social distance.
-She could not remember if any residents on the AL side wore face masks.
-In early March 2020, she had educated the MA/S regarding the importance of protecting residents from COVID-19: residents to wear face masks and social distance, resident COVID-19 screening, and assessing resident temperatures.

Telephone interview with a Clinical Nurse Supervisor (CNS) with the local health department (LHD) on 09/28/20 at 2:36pm revealed:
-Residents were expected to wear face masks in the facility when they were out of their room.
-Staff were expected to prompt all residents to wear face masks and utilize social distancing to decrease the spread of COVID-19.

Refer to telephone interview with the facility manager on 09/25/20 at 10:38am.

_____

Telephone interview with the Facility Manager on 09/25/20 at 10:38am revealed:
-She last looked at the CDC website one week ago.
-She tried to look at the CDC website every week.
-She did not always have time to review the CDC website on a weekly basis.

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D 338	Continued From page 107 -"I'm doing the best I can do". -She received emails from the North Carolina Department of Health and Human Services (NC DHHS) regarding COVID-19 updates. -She did not know the last time she read the emails from NC DHHS regarding COVID-19 updates. -She would keep the emails in her email box. -She would not print out the emails to refer to. -In July 2020, she provided a video for staff to watch regarding COVID-19 which was due by 08/05/20. -She talked to staff when she had received new guidance about COVID-19. _____ The facility failed to implement and adhere to the guidelines and recommendations established by the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the global COVID-19 pandemic. One resident tested positive for COVID-19 on August 3, 2020 and the local health department was not notified by the facility. Screening recommendations related to temperature checks for staff, visitors, and residents were completed with a ear thermometer used incorrectly on the forehead resulting in inaccurate temperature readings and the facility being unable to determine if residents, staff or visitors, had a temperature. The staff failed to wear personal protective equipment correctly. Residents were not required to wear face masks or practicing social distancing to decrease the spread of COVID-19 and staff did not prompt the residents and were not aware of the CDC guidance on use of masks and social distancing. The facility failed to adhere to basic infection control recommendations including providing appropriate hand hygiene supplies for resident	D 338		

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D 338	Continued From page 108 use and environmental cleaning and disinfecting using environmental protection agency (EPA) approved disinfectants. The facility's failure placed all residents at increased risk for transmission and infection from the deadly COVID-19 virus, resulting in substantial risk of serious harm and neglect, which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on September 29, 2020 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2020.	D 338		
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 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: TYPE A1 VIOLATION The facility failed to ensure sufficient staff were on duty at all times to meet the needs of 11 residents residing in the special care unit (SCU)	D 465		

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including 4 of 4 sampled residents (#1, #2, #3, #4) who consistently required assistance from two or more staff with incontinent care and other personal care tasks resulting in no staff being available to monitor and/or assist the remaining residents.

The findings are:

Review of documentation identified by the Manager as the special care unit (SCU) policies revealed:
-The facility offered a high staff to resident ratio and offered a registered nurse (RN), licensed practical nurse (LPN), and nursing assistants (NAs) to meet residents' individual needs.
-Each resident would have an individual service plan completed which included level of care, routines, and special needs.
-The facility provided the level of care needed to the point where residents would be dependent upon staff for total care.
-The resident to staff ratio would provide 1 staff to 8 residents and one hour of staff time for each additional resident on 1st and 2nd shifts.
-The resident to staff ratio would per 1 staff to 10 residents and 0.8 hour of staff time for each additional resident on 3rd shift.

Review of the census report on 09/24/20 revealed eleven residents resided in the special care unit (SCU).

Observation on 09/24/20 from 10:40am - 11:20am and 12:30pm - 1:00pm revealed there were 2 personal care aides (PCAs) on duty in the SCU.

Observation of the SCU on 09/24/20 from 12:30 - 12:48pm revealed:

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D 465	Continued From page 110 -There were eight residents in the common living room and all residents were disoriented. -Resident #3 was wandering in the common living room pulling at a cable box that was plugged into an electrical outlet and the television. -Resident #2 was yelling for someone to remove Resident #3 from the living room. -There was no staff in the living room to supervise the eight residents. -There were two PCA's in the dining room cleaning. -One PCA pushed a trash can out of the dining room and entered a resident room. -The other PCA exited the dining room and went into the same resident room. -Both PCA's exited the staff room and went into the living room with the eight residents. Interview with a PCA on 09/24/20 at 12:49pm revealed: -She and the other PCA were providing personal care to a resident who required 2:1 (2 staff to 1 resident) assistance. -There were eight residents in the SCU who required 2:1 assistance for personal care. -It took approximately 20 minutes to bath and dress those 4 residents. -There was no other staff available to supervise or assist other residents when providing personal care to the residents who required 2:1 assistance. -She had not asked for help supervising the residents when providing PC because there was only one medication aide/supervisor (MA/S) and one PCA available on the assisted living (AL) side. -The door would be left open when bathing or toileting a resident who required 2:1 assistance so one PCA could keep looking out the door for other residents. -Sometimes a resident would be placed in the	D 465		

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room for supervision with the two PCA's when providing 2:1 personal care assistance to another resident.

Interview with a MA/S on 09/24/20 at 1:41pm revealed:
-There were five residents in the SCU who required 2:1 assistance for personal care.
-There were about 3 - 4 residents on 1st shift who were showered and dressed that required 2:1 personal care assistance.
-There were about 2 residents on 2nd shift who were showered and dressed that required 2:1 personal care assistance.
-One month ago, she assisted the SCU staff in providing personal care assistance for a resident.
-It would take 20 - 30 minutes for two staff to provide personal care to those five residents.
-At that time, resident required three staff assistance for personal care. She did not remember who the resident was.
-The two SCU PCA's would give about 3 - 4 resident baths on 1st shift and two resident baths on 2nd shift.
-There were three residents in the SCU who exhibited aggressive behaviors and were combative by hitting and slapping other residents and using foul language.
-There were only two PCAs scheduled during 1st, 2nd, and 3rd shift in the SCU.
-There was one MA/S scheduled to cover the SCU and the assisted living during 1st, 2nd, and 3rd shift.
-When a resident required 2:1 assistance in the SCU, the staff would leave the resident room or bathroom door open when providing personal care and would "stick their heads out the door and look down the hall towards the living room" to monitor the other residents in the SCU.
-The two PCA in the SCU could safely care for

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the all the residents when providing personal care for other residents including the residents who required two staff assistance with personal care.
-The two PCA's could provide supervision to the other ten residents in the SCU when providing two-person personal care assistance to one resident in the SCU.
-She had never been asked by the SCU staff to help supervise residents in the SCU while SCU staff were assisting other residents with personal care.

Telephone interview with the Facility Manager on 09/25/20 at 10:08am revealed:
-There were always two staff in the SCU.
-There were four residents in the SCU who required 2:1 assistance for personal care.
-Three of the residents would become combative by hitting other residents or using foul language.
-All SCU residents were incontinent and required every two hour incontinent checks.
-SCU staff would ask for assistance if a resident required 2:1 assistance for personal care.
-If needed, the MA/S would supervise residents in the SCU while staff performed 2:1 assistance.
-Sometimes the AL PCA would assist staff in the SCU when 2:1 assistance was needed.
-She did not know the last time the AL PCA assisted SCU staff.
-When SCU staff were performing 2:1 assistance there would be no other staff available to supervise or assist the other residents.
-When SCU staff were performing 2:1 assistance the other residents were left unsupervised in the in the living room or their bedrooms.
-She did not have any concerns regarding the SCU residents when both PCA's were providing 2:1 assistance.
-The MA/S had never been called to assist staff in the SCU the best she could remember.

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-The SCU residents may need to be reassessed to determine their appropriate level of care needed.
-She had not contacted the Administrator for extra staff coverage because she did not think staffing in the SCU was a concern.

Telephone interview with a second MA/S on 09/29/20 at 9:23am revealed:
-All the 11 residents in the SCU required incontinent care.
-Three of the incontinent residents required 2:1 assistance for personal care.
-It could take up to 10 - 15 minutes or less to provide incontinent care to residents in the SCU that required 2:1 assistance.

1. Review of Resident #2's current FL-2 dated 11/06/19 revealed:
-Diagnoses included Alzheimer's, stroke, and chronic pulmonary disorder.
-The resident was ambulatory, intermittently disoriented and required staff assistance with bathing, feeding, and dressing.
-The resident was incontinent of bowel and bladder.

Review of Resident #2's current care plan dated 09/23/20 revealed:
-The resident required supervision for eating, ambulation, and transfers.
-The resident required extensive assistance for toileting, bathing, dressing, and grooming.
-The resident was sometimes disoriented, forgetful needing reminders, and had limited ability sometimes with an unsteady gait.
-The resident wore adult briefs and required bowel and bladder training every two hours.

Observation of Resident #2 on 09/24/20 at

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D 465	Continued From page 114 12:30pm revealed the resident was sitting in a wheelchair in the living room pointing at and yelling for someone to remove another resident from the living room. Interview with the personal care aide (PCA) on 09/24/20 at 12:49pm revealed: -Resident #2 could not walk and depended upon a wheelchair for mobility -Resident #2 required 2:1 (2 staff to 1 resident) assistance with personal care. -It took 20 minutes to bath and dress Resident #2. -Resident #2 was confused. Telephone interview with the Facility Manager on 09/25/20 at 10:30am revealed: -Resident #2 required 2:1 assistance for personal care including incontinent care. -At times, Resident #2 would have increased behaviors and become combative and agitated. -Resident #2 had been in an altercation with another resident earlier in the week during 3rd shift. -The SCU staff were assisting other residents, leaving Resident's #2 and the other resident unsupervised in the living room when the altercation occurred. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to telephone interview with the facility's contracted Primary Care Provider (PCP) on 09/28/20 at 12:00pm. Refer to the telephone interview with the Facility Manager on 09/30/20 at 10:30am.	D 465		

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D 465	Continued From page 115 Refer to the telephone interview with the Administrator on 09/30/20 at 4:00pm. 2. Review of Resident #3's current FL-2 dated 10/20/19 revealed: -Diagnoses included Alzheimer's, dementia psychosis, lymphoid leukemia, hyperlipidemia, insomnia, hypertension, gastroesophageal reflux disease, and hypokalemia. -Resident #3's level of care was documented as special care unit. -Resident #3 was ambulatory, constantly disoriented, and incontinent. -Resident #3 required staff assistance with bathing, feeding, and dressing. Review of Resident #3's care plan dated 09/23/20 revealed: -Resident #3 was always disoriented. -Resident #3 required total assistance from staff with toileting, bathing, dressing, and grooming and required bowel and bladder training every two hours. -Resident #3 required staff supervision with ambulation and transferring. Review of Resident #3's previous care plan dated 07/01/20 revealed: -Resident #3 was always disoriented. -Resident #3 required total assistance from staff with toileting, bathing, dressing, and grooming. -Resident #3 required staff supervision with eating, ambulating, and transferring. Observation of Resident #3 on 09/24/20 from 12:30pm - 1:00pm revealed: -The resident was in the Special Care Unit (SCU) living room pulling at a cable box and cords. -There had been no staff available to monitor the resident.	D 465		

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-The resident wandered up and down the hallway and into resident rooms.
-The resident pushed on the entrance and exit doors.

Interview with a personal care aide (PCA) on 09/24/20 at 12:49pm revealed:
-Resident #3 required 2:1 (2 staff to 1 resident) assistance with personal care.
-It took 20 minutes to bathe and dress Resident #3.
-Resident #3 was confused, threw plates and cups at and hit other residents, wandered, and would climb on chairs.

Telephone interview with the Manager on 09/25/20 at 10:30am revealed:
-Resident #3 required 2:1 assistance for personal care at times but not every day.
-Resident #3 had behaviors that required her to be supervised by staff more frequently at times.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

Refer to telephone interview with the facility's contracted Primary Care Provider (PCP) on 09/28/20 at 12:00pm.

Refer to the telephone interview with the Facility Manager on 09/30/20 at 10:30am.

Refer to the telephone interview with the Administrator on 09/30/20 at 4:00pm.

3. Review of Resident #1's current FL-2 dated 03/02/20 revealed:
-Diagnoses included dementia, Parkinson's disease, and schizoaffective disorder bipolar type.

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D 465	Continued From page 117 -The resident was constantly disoriented, incontinent of bowel and bladder, semi ambulatory with a walker, and required staff assistance with bathing, feeding, and dressing. Review of Resident #1's current care plan dated 09/23/20 revealed: -The resident required supervision with eating. -The resident required limited assistance with ambulation requiring a walker or ambulation with staff. -The resident required extensive assistance with dressing. -The resident was totally dependent upon staff for toileting, bathing, and grooming. -The resident was incontinent of bowel and bladder requiring bowel and bladder training every two hours. -The resident was always disoriented and forgetful requiring reminders. Review of Resident #1's previous care plan dated 07/01/20 revealed: -The resident was totally dependent upon staff for toileting, bathing, and grooming. -The resident required extensive assistance with dressing. -The resident required limited assistance with ambulation requiring a walker or ambulation with staff. -The resident required supervision with eating and transferring. Interview with the personal care aide (PCA) on 09/24/20 at 12:49pm revealed: -Resident #1 was ambulatory with a walker. -Resident #1 required 2:1 (2 staff to 1 resident) assistance with personal care. -It took 20 minutes to shower/bathe and dress Resident #1.	D 465		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 118 -Resident #1 was in an altercation with another resident about three days ago while unsupervised in the living room. Telephone interview with the Manager on 09/25/20 at 9:58am revealed: -Resident #1 had been in an altercation with another resident earlier in the week during 3rd shift. -The Special Care Unit (SCU) staff were assisting other residents leaving Resident's #1 and the other resident unsupervised in the living room when the altercation occurred Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Refer to telephone interview with the facility's contracted Primary Care Provider (PCP) on 09/28/20 at 12:00pm. Refer to the telephone interview with the Facility Manager on 09/30/20 at 10:30am. Refer to the telephone interview with the Administrator on 09/30/20 at 4:00pm. 4. Review of Resident #4's current FL-2 dated 01/27/20 revealed: -There was a diagnosis of Alzheimer's. -Resident #4's level of care was documented as special care unit. -Resident #4 was ambulatory, constantly disoriented, and incontinent. -Resident #4 was totally dependent upon staff for assistance with personal care. Review of Resident #4's care plan dated 09/23/20 revealed:	D 465		

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-Resident #4 was always disoriented.
-Resident #4 had significant memory loss and must be directed.
-Resident #4 had frail skin.
-Resident #4 wore glasses and was hard of hearing.
-Resident #4 required total assistance from staff with bathing, dressing, and grooming.
-Resident #4 required bowel and bladder training every 2 hours.
-Resident #4 required limited assistance with ambulation and used a wheelchair.

Interview with a personal care aide (PCA) on 09/24/20 at 12:49pm revealed:
-Resident #4 used a wheelchair and was a fall risk.
-Resident #4 would try to walk at times.
-Resident #4 was pushed in her wheelchair into the bathroom with the two PCA staff when they performed 2:1 (2 staff to 1 resident) assistance to other residents because there was no other staff available in the SCU to monitor the resident.
-Two months ago, she and another PCA were bathing another resident when she looked up and saw Resident #4 fall.
-Resident #4 was dependent upon a wheelchair after the fall.

Review of the Emergency Room (ER) Provider note dated 06/25/20 revealed:
-Resident #4 arrived in the Emergency Room (ER) on 06/25/20 after a fall with loss of consciousness and facial laceration.
-Resident #4's head exam demonstrated a centimeter flap-like laceration over her forehead at the nasal bridge.
-Resident #4 had computed topography scan (CT) on 06/25/20 in the ER.
-Resident #4 had significant bleeding and

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required eleven sutures to the flap-like laceration over her forehead at the nasal bridge.

Review of Resident #4's CT scan on 06/25/20 revealed:
-Resident #4 had a depressed fracture of the nasal bone.
-Resident #4's medial and lateral pterygoid plates (bones of face) had been fractured on the left.
-There had been displaced fragments from the fractured lateral wall of the left maxillary sinus.
-There had been diffuse soft tissue swelling over the nasal bone.
-There had been no evidence of orbital fractures.
-There had been no evidence of skull base fractures.

Telephone interview with the facility Manager on 09/320/20 at 10:30am revealed Resident #4 required 2:1 assistance personal care at varying times.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

Refer to telephone interview with the facility's contracted Primary Care Provider (PCP) on 09/28/20 at 12:00pm.

Refer to the telephone interview with the Facility Manager on 09/30/20 at 10:30am.

Refer to the telephone interview with the Administrator on 09/30/20 at 4:00pm.

_____

Telephone interview with the facility's contracted Primary Care Provider (PCP) on 09/28/20 at 12:00pm revealed:
-All residents in the SCU were incontinent and

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required 2:1 (2 staff to 1 resident) assist for incontinent care.
-In her professional opinion, the Special Care Unit (SCU) needed at least one additional person staffing when 2:1 care was being performed.
-All the residents in the SCU were fall risks and it was unacceptable to leave the residents unsupervised when staff were performing 2:1 care.
-There was not enough staff in the SCU to provide care to all the residents when staff were performing 2:1 assistance.
-There should always be one staff person in the SCU living room when occupied by any resident.

Telephone interview with the Facility Manager on 09/30/20 at 10:30am revealed:
-The facility had three shifts: 7:00am-3:00pm was first shift; 3:00pm-11:00pm was second shift, and 11:00pm-7:00am was third shift.
-Staff did not clock out for lunch and when they went on break, another staff was sent to the SCU to cover for the staff while they were on break.
-She was responsible for making the staffing schedule for assisted living (AL) and the SCU.
-She made the schedule for the SCU based on the census.
-The current census in the SCU was 11 residents.
-There were two staff scheduled for each shift in the SCU and there was one supervisor on duty on each shift that covered the entire facility (SCU and assisted living).
-Sometimes, these residents required assistance from three staff; when this happened, assistance was provided by the supervisor or AL staff and the two SCU staff.
-There were 3 residents in the SCU who required increased supervision "at times" due to their behaviors.
-She did not know 2 staff were observed to have

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been off the floor while providing personal care to one resident for 18 minutes, leaving the other residents without staff available to provide assistance and supervision to other residents.
-The Administrator "may" look at the staffing schedule, but she had never provided him with a copy of the schedule, and he had never asked her for a copy of the schedule.
-She acknowledged she did not make the SCU schedule based on the needs of the residents, she just always scheduled 2 direct care staff for each shift.
-Prior to today (09/30/20), there had not been a plan in place in the SCU to ensure staffing met the residents' needs, but she had begun the process of adding more staff.

Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed:
-The Manager was responsible for staff scheduling in the SCU.
-When a resident required assistance from more than one staff, the SCU staff should be calling the supervisor for help when they had to leave the floor.
-The MA/S should be going into the SCU so there was always a staff available for the residents.

Refer to tag D 270 10A NCAC 13F.0901(b) Personal Care and Supervision.

Refer to tag D 269 10A NCAC 13F.0901(a) Personal Care and Supervision.

_____

The facility failed to ensure sufficient staff was on duty in the special care unit (SCU) at all times to meet the assessed needs of the residents. All eleven residents in the SCU required staff assistance with incontinent care. 4 of 4 sampled residents (#1, #2, #3, #4) required assistance

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D 465	Continued From page 123 from two staff for their personal care, resulting in no staff being available to assist and provide supervision to the other residents when the two scheduled staff were providing care to residents who required assistance of two staff and residents being left alone without staff present for 18 minutes on 09/24/20. The door would be left open by staff when they were bathing and/or toileting a resident who required 2:1 assistance so they could keep looking out the door for the other residents, resulting in staff not maintaining the privacy and dignity of the residents. On 06/25/20, the two staff on duty were bathing a resident who required 2:1 assistance and were unavailable to assist Resident #4. Resident #4 fell and sustained multiple facial fractures and a facial laceration that required eleven sutures. The facility's failure to have sufficient number of staff in the SCU to meet the residents needs resulted serious neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 29, 2020 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2020.	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.	D 466		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a care coordinator was on duty in the special care unit (SCU) at least 8 hours per day, 5 days per week to oversee resident care, which included coordinating, supervising, and evaluating resident services to ensure each resident received care and services appropriate to each resident's needs.

The findings are:

Review of documentation identified by the Facility Manager as the special care unit (SCU) policies revealed:
-Each resident would have an individual service plan completed which included level of care, routines, and special needs.
-There would be at least one care coordinator for the SCU.

Observation on 09/24/20 revealed there was no designated SCU coordinator on duty.

Telephone interview with the Facility Manager on 09/30/20 at 10:30am revealed:
-Herself and the Administrator were responsible for managing the overall operations of the facility.
-There was a personal care aide (PCA) who worked in the SCU 5 days per week who was the care coordinator for the SCU.
-The SCU coordinator's duties included overseeing the SCU to ensure residents were taken care of and staff were doing what they were supposed to be doing.
-The SCU coordinator notified the supervisor on

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D 466	Continued From page 125 duty or her of any identified concerns at the time of identification. Telephone interview with the staff identified by the Facility Manager as the SCU care coordinator on 09/30/20 at 11:31am revealed: -Her title was a personal care aide. -Her job responsibilities included working in the SCU and making sure staff did their job. -She was responsible for helping resident with meals during meal times, cleaning the SCU, and helping with activities of daily living for residents. -She worked in the SCU 5 days a week from 7:00am to 3:30pm. -If staff had a concern with a resident, she would notify the medication aide/supervisor (MA/S). -The Facility Manager and the MA/Ss supervised resident services. -The MA/Ss evaluated residents for services they would be appropriate for. -The MA/Ss were responsible for contacting the residents' primary care physician. -She knew the services the residents needed because it had been common sense. -She did not know any other way to determine what services residents needed. Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed: -There was no staff member designated as the care coordinator for the SCU. -A registered nurse (RN) came in to complete residents' care plans. -The direct care staff (nursing assistants and MA/Ss) of the SCU and the Facility Manager were responsible for ensuring residents' care needs were met. Refer to Tag 465 10A NCAC 13F. 1308(a) Special Care Unit Staffing.	D 466		

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D 466	Continued From page 126 Refer to Tag 255 10A NCAC 13F. 0801(c) Resident Assessment.	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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to other resident care and services. The findings are: Based on interviews, observations, and record reviews the facility failed to ensure transportation was available to transport residents to medical appointments resulting in 2 of 2 sampled residents (#1,#3) not having transportation to the hospital and medical appointments. [Refer to Tag 321, 10A NCAC 13F. 0906(a) Other Resident Care and Services Resident Rights (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights	D914		

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D914	Continued From page 127 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 provided with the necessary care and services to maintain their physical and mental health as related to resident rights, personal care and supervision, health care, special care unit staffing, and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the routine and acute health care needs were met for 4 of 4 sampled residents (#1, #2, #3, #4,) related to failing to notify the primary care provider (PCP) of three residents exhibiting behaviors harmful to themselves and /other residents (#1, #2, #3); failing to notify the PCP of a physical altercation between two residents resulting in bruising to one resident in which the injury was not reported to the PCP (#1, #2); failing to ensure PCP notification and emergent medical evaluation of an oxygen saturation result of 75% and blood pressure of 72/33 and a fall with a head injury (#3); failure to ensure three residents attended medical appointments as ordered (#1, #2, #3); and a delay in setting up home health for a resident with pressure ulcers (#4). [Refer to tag D 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. The facility failed to ensure sufficient staff were on duty at all times to meet the needs of 11	D914		

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residents residing in the special care unit (SCU) including 4 of 4 sampled residents (#1, #2, #3, #4) who consistently required assistance from two or more staff with incontinent care and other personal care tasks resulting in no staff being available to monitor and/or assist the remaining residents. [Refer to tag D 465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A1 Violation)].

3. Based on observations, interviews, and record reviews the facility failed to provide supervision to 2 of 3 sampled residents (#2, #3) with cognitive impairment and mental health diagnoses who resided on the special care unit (SCU). Refer to tag D 270 10A NCAC 13F.0901(b) Personal Care and Supervision (Type A2 Violation)].

4. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to failure to notify their local health department (LHD) for a resident who tested positive for COVID-19; screening of visitors; use of personal protective equipment (PPE) by staff and residents; practicing social distancing amongst residents; infection control procedures related to maintaining environmental cleanliness and use environmental protection agency (EPA) approved disinfectants to reduce the risk of transmission and infection with the deadly virus. [Refer to Tag D338, 10A NCAC 13F.0909 Resident Rights (Type A2 Violation)].

5. Based on observations, interviews and record

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D914	Continued From page 129 review, the facility failed to ensure foot care and repositioning was provided for 1 of 4 sampled residents (#4) resulting in unstageable pressure ulcers to both her left and right heels. [Refer to tag D 269 10A NCAC 13F.0901(a) Personal Care and Supervision (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 and Facility Manager failed to ensure management and total operations of the facility were maintained to ensure substantial compliance with the rules and statutes of adult care homes to protect each residents' right to receive adequate and appropriate care and services and to be free of neglect as related to resident rights, personal care and supervision, special care unit staffing, other resident care and services, and health care. Interview with the first medication aide/supervisor (MA/S) on 09/24/20 at 10:06am revealed the Facility Manager was not currently at the facility; she was at another (sister) facility. Telephone interview with the first MA/S on 09/25/20 at 9:56am revealed the Facility Manager	D980		

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was not currently at the facility; she was at another (sister) facility.

Telephone interview with the Facility Manager on 09/25/20 at 9:58am revealed:
-The Administrator had been out of the facility on leave for about 3 weeks.
-She had been functioning as the Administrator since the Administrator's leave.
-She and the Administrator would talk weekly since he had been out of the facility.
-She had not told the Administrator about the facility survey.
-She had not told the Administrator of the requested Plans of Protections.
-She had not had any reasons to contact the Administrator since he had been on leave.

Telephone interview the first MA/S on 09/28/20 at 9:56am revealed:
-She would contact the Facility Manager for guidance instead of the Administrator because the Facility Manager was her point of contact.
-She last saw the Administrator at the facility 2 - 3 months ago to meet with the Facility Manager.

Telephone interview with the facility's contracted Primary Care Provider (PCP) revealed:
-She met the Administrator about 1 - 2 years ago.
-She made visits to the facility every two weeks.
-She had never seen the Administrator at the facility during her visits.

Telephone interview with the first MA/S on 09/29/20 at 8:30am revealed the Facility Manager was not currently at the facility; she was at another (sister) facility.

Telephone interview with a second MA/S on 09/30/20 at 8:26am revealed:

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D980	Continued From page 131 -She referred to the Facility Manager as the Administrator. -The Facility Manager had not arrived at the facility for the day. -The first MA/S was the head MA/S because she had been there longer. -She asked the first MA/S if she had a question about the facility or anything resident related. -She would even call the first MA/S when she was off work and on weekends. -If the first MA/S did not know the answer, then she would ask the Facility Manager. -The Facility Manager worked at the facility 2 to 3 times per week. -The Facility Manager would come into the facility between 8:00am and 9:00am. -The Facility Manager would work as late as 5:00pm when she had worked at the facility. -The Facility Manager had not worked on the weekend. -When the Facility Manager was not at the facility, she was accessible by telephone except on the weekends. -The Facility Manager had never answered her phone when the MA/S had called her on the weekend. -She had never called the Administrator, she had never been instructed to call the Administrator for anything. -The Facility Manager had arrived at the facility at 9:18am on 09/30/20. Telephone interview with the Facility Manager on 09/30/20 at 10:30am revealed: -Her and the Administrator were responsible for managing the overall operations of the facility. -She was in the facility 3 to 4 times per week and stayed 8 hours or more each day she was there. -Any issues identified by staff were brought to the attention of the supervisor (which was the	D980		

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	HAL096009	A. BUILDING: _____ B. WING _____	C 10/02/2020

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D980	Continued From page 132	D980		

medication aide on duty).
-The MA/S notified her if they needed "advice" or for any situation with a staff or resident "they can't handle."
-When she was not in the facility, she was always available to staff by telephone. Staff called her twenty-four hours per day, seven days per week.
-Staff would not call the Administrator, they would call her.
-If the Administrator needed to be contacted, she would call him.
-The Administrator had told her that he was always available.
-She notified the Administrator of anything she could not "take care of" or anything "serious" when they talked during their weekly meetings.
-Examples of when she would notify the Administrator included when residents fell or were injured such as sustaining a broken bone, incidents of resident to resident abuse, or residents exhibiting behaviors harmful to themselves or others.
-During the time she was at the facility, she checked with the MA/S to find out what had gone on for the shift, walked through the entire building, talked with staff and residents, completed paperwork, and helped wherever she was needed.
-The paperwork she completed included looking at resident records if the resident had been sent out to the hospital, reviewing policies, completing payroll, and paying bills.
-She spoke with the Administrator weekly and they discussed what was going on in general in the facility.
-The Administrator was last at the facility the "week before last."
-Prior to being onsite the week before last, the Administrator had not been to the facility "lately"

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D980	Continued From page 133	D980		

(she did not know the date of the Administrator's last visit because he had been out of work) but was available by phone.
-She thought the facility had a behavior policy, but she did not know the policy off the top of her head and would not want to say what the policy was without reading it first.
-She had never been provided with a copy of the facility's special care unit (SCU) policies and would have to look for the SCU policies.
-She was "not sure" how she could oversee the SCU to ensure the SCU policies were being followed since she did not know the policies.

Telephone interview with the Administrator on 09/30/20 at 4:00pm revealed:
-He and the Facility Manager were responsible for the overall operations of the facility.
-He could not be at the facility twenty- four hours per day, seven days per week.
-The Facility Manager had "full authority" of the overall operations of the facility when he was not there.
-The Facility Manager worked 5 days per week and sometimes on the weekends, rotating between two facilities.
-The Facility Manager worked 2 -3 days per week at each of the two facilities and "covered" both facilities.
-The Facility Manager was on call for the facility twenty- four hours per day, seven days per week and was always accessible to staff.

Telephone interview with the Facility Manager on 10/01/20 at 11:10am revealed:
-It was her responsibility to make sure facility policies and procedures followed the state rules and regulations.
-She had not looked at her state rule book in over a month because she had been busy filling other

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D980	Continued From page 134 roles at the facility such as cooking. -She had never been told that the other MA/S had been calling the first MA/S even when she had not been working before, they called her if they had a question or needed something. -She had never received training on her current role as the Facility Manager. -She knew how to function as the Facility Manager because of her work experience at other facilities throughout previous years. -She did not know why the Administrator said it was her role to schedule and reschedule resident appointments. -It had always been the responsibility of the MA/S to schedule and reschedule resident appointments. Non-compliance was identified at violation level in the following rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the routine and acute health care needs were met for 4 of 4 sampled residents (#1, #2, #3, #4,) related to failing to notify the primary care provider (PCP) of three residents exhibiting behaviors harmful to themselves and /other residents (#1, #2, #3); failing to notify the PCP of a physical altercation between two residents resulting in bruising to one resident in which the injury was not reported to the PCP (#1, #2); failing to ensure PCP notification and emergent medical evaluation of an oxygen saturation result of 75% and blood pressure of 72/33 and a fall with a head injury (#3); failure to ensure three residents attended medical appointments as ordered (#1, #2, #3); and a delay in setting up home health for a resident with pressure ulcers (#4).[Refer to tag D 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].	D980		

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D980	Continued From page 135 2. The facility failed to ensure sufficient staff were on duty at all times to meet the needs of 11 residents residing in the special care unit (SCU) including 4 of 4 sampled residents (#1, #2, #3, #4) who consistently required assistance from two or more staff with incontinent care and other personal care tasks resulting in no staff being available to monitor and/or assist the remaining residents. [Refer to tag D 465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews the facility failed to provide supervision to 2 of 3 sampled residents (#2, #3) with cognitive impairment and mental health diagnoses who resided on the special care unit (SCU). Refer to tag D 270 10A NCAC 13F.0901(b) Personal Care and Supervision (Type A2 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to failure to notify their local health department (LHD) for a resident who tested positive for COVID-19; screening of visitors; use of personal protective equipment (PPE) by staff and residents; practicing social distancing amongst residents; infection control procedures related to maintaining environmental cleanliness and use environmental protection agency (EPA) approved disinfectants to reduce the risk of transmission and infection with the deadly virus. [Refer to Tag D338, 10A NCAC	D980		

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D980	Continued From page 136 13F.0909 Resident Rights (Type A2 Violation)]. 5. Based on observations, interviews and record review, the facility failed to ensure foot care and repositioning was provided for 1 of 4 sampled residents (#4) resulting in unstageable pressure ulcers to both her left and right heels. [Refer to tag D 269 10A NCAC 13F.0901(a) Personal Care and Supervision (Type B Violation)]. 6. Based on interviews, observations, and record reviews the facility failed to ensure transportation was available to transport residents to medical appointments resulting in 2 of 2 sampled residents (#1, #3) not having transportation to the hospital and medical appointments. [Refer to tag D 321 10A NCAC 13F .0906(a) Other Resident Care and Services (Type B Violation)]. _____ The Administrator failed to ensure staff adhered to the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and the North Carolina Department of Health and Human Services (NC DHHS) to protect the residents from infection and transmission of Coronavirus (COVID-19) during the global pandemic; failed to ensure a system was in place for referral and follow up to meet the health care needs of the residents resulting in the primary care provider (PCP) not being notified of an altercation between residents, residents with cognitive impairment who exhibited behaviors that were harmful to themselves and or other residents not being reported and no safety interventions implemented; missed mental health and specialty health care appointments; delayed evaluation and treatment after a fall with injury; failure to notify the PCP of low oxygen saturation of 75% and low blood pressure of 72/33; failed to ensure staffing	D980		

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D980	Continued From page 137 in the special care unit (SCU) was maintained to meet the needs of the residents resulting in no staff being available to supervise and/or assist the resides when the two staff on duty were assisting four residents who required assistance from two staff for personal care resulting in violations of the residents' right to privacy and dignity; and one resident developing unstageable wounds on her heels when staff did not reposition or assist out of the wheel chair every two hours. The Administrator's failure resulted in serious physical harm and neglect of the residents, which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 1, 2020 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 1, 2020.	D980		