| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE LYMAN HOUSE | 900 KENREED DR THOMASVILLE, NC 27360 |

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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a Complaint Investigation with an onsite visit on 03/01/21 and a desk review survey on 03/02/21 through 03/04/21 with an exit via telephone on 03/04/21. | C 000 | | |
| C 185 | 10A NCAC 13G .0601(a) Management and Other Staff<br><br>10A NCAC 13G .0601Mangement and Other Staff<br>(a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on record reviews and interviews, the facility failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each resident's rights as evidenced by the failure to maintain substantial compliance with the rules and statues governing adult care homes related to residents' rights, discharge of residents, and health care. | C 185 | | |

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| C 185 | Continued From page 1<br><br>The findings are:<br><br>Interview with the Owner on 03/01/21 at 11:30am revealed:<br>-She no longer had an Administrator at the facility.<br>-Less than one hour ago, she and the Administrator had a conversation and she decided that she was closing the facility today.<br>-The Administrator submitted his resignation today, 03/01/21.<br>-She planned to close the facility and was getting ready to call all the residents' family to have them come to the facility and pick up the residents today.<br>-There was no nurse at the facility, and she had no one in charge.<br>-The Supervisors were to handle everything until the last resident moved out of the facility.<br>-She was not allowed in the facility where the residents' lived.<br>-She had not given the residents' a notice of discharge.<br>-She had just made the decision to close the facility today.<br>-She had not contacted the local County Department of Social Services to inform them of her plan to close the facility.<br><br>Interview with the Administrator on 03/01/21 at 9:53am revealed:<br>-He worked a full-time job, but he tried to come to the facility for at least an hour daily.<br>-Staff were supposed to report to him, but staff usually reported to the Owner.<br>-If there was an emergency, staff were to call the facility's licensed practical nurse (LPN), who worked a full-time job outside of the facility and was only at the facility 2 to 3 days a week.<br>-If staff could not get in contact with the LPN, they | C 185 | | |

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| C 185 | Continued From page 2 | C 185 | | |

were to contact the Owner and then call him if the Owner was not available.

Interview with Supervisor on 03/01/21 at 10:58am revealed:
-She contacted the facility LPN if she had any issues.
-The LPN worked full-time at another job and did not always answer her phone.
-If the LPN was not available, she contacted the Owner.
-She only saw the Administrator at the facility office about 2 days a week.

A second telephone interview with the Administrator on 03/01/21 at 3:20pm revealed:
-Today, 03/01/21, he reported his resignation as the facility's Administrator to the Owner.
-He had another full-time job and did not have the time needed to help the facility.
-He felt the facility needed a full-time Administrator.
-He did not know who would be in charge of the facility since his resignation.

Non-compliance was identified in the following rule areas:

1. Based on record reviews and interviews the facility failed to ensure each resident was treated with respect, consideration, and dignity related to residents being woken out of their sleep and transported to another facility without prior knowledge (Resident #2 and #3). [Refer to Tag 0311, 10A NCAC 13G .0909 Residents' Rights (Type A1 Violation)].

2. Based on record review and interviews, the facility failed to ensure a safe and orderly discharge for 2 of 2 sampled residents (Resident

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| C 185 | Continued From page 3<br>#2 and #3). [Refer to Tag 0224, 10A NCAC 13G .0705 Discharge of Residents (Type B Violation)].<br><br>3. Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled resident received healthcare referral and follow-up services related to physician's orders for a podiatry consult, a physical therapy consult, and a wound care consult (Resident #1). [Refer to Tag 0246, 10A NCAC 13G .0902(b) Health Care (Type B Violation)].<br><br>4. Based on observations, record reviews, and interviews, the facility failed to ensure weights were completed and documented as ordered for 1 of 1 sampled resident (Resident #1) with orders to check weight bi-monthly and weekly. [Refer to Tag 0249, 10A NCAC 13G .0902(c) (3-4) Health Care (Standard Deficiency)].<br><br>_____<br>The Administrator failed to ensure the overall management and operations of the facility were implemented by failing to ensure staff were available to care for residents during each working shift, residents' rights were maintained by not awakening them in the middle of the night and moving them to another facility without their personal belongings and medications, residents were properly notified of plans of an immediate discharge from the facility, a resident received appropriate specialized care after the facility received a physician's order for a podiatry consult due to a thickened, yellow, detaching toenail, a wound care consult due to a decubitus ulcer, physical therapy for transfers and gait training, and weekly weights were implemented (Resident #1). This failure resulted in serious physical harm, neglect of the residents, and the death of Resident #1 which constitutes a Type A1 Violation. | C 185 | | |

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| C 185 | Continued From page 4<br>_____<br>The facility failed to provide an adequate plan of protection in accordance with G.S. 131D-34 on 03/03/21 for this violation. | C 185 | | |
| C 224 | 10A NCAC 13G .0705 (f) Discharge Of Residents<br><br>10A NCAC 13G .0705 Discharge Of Residents<br><br>(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:<br>(1) notifying staff in the county department of social services responsible for placement services;<br>(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;<br>(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and<br>(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:<br>(A) a copy of the resident's most current FL-2;<br>(B) a copy of the resident's most current assessment and care plan;<br>(C) a copy of the resident's current physician orders;<br>(D) a list of the resident's current medications;<br>(E) the resident's current medications; and<br>(F) a record of the resident's vaccinations and TB screening.<br>(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule: | C 224 | | |

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| C 224 | Continued From page 5<br>(A) the regional long term care ombudsman; and<br>(B) the protection and advocacy agency established under federal law for persons with disabilities.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on record review and interviews, the facility failed to ensure a safe and orderly discharge for 2 of 2 sampled residents (Resident #2 and #3).<br><br>The findings are:<br><br>1. Review of Resident #2's current FL2 date 11/09/20 revealed:<br>-Diagnoses included end stage renal disease (dialysis), anemia, type II diabetes mellitus, thrombocytopenia, vasculittis, right hip replacement, left hip replacement.<br>-Resident #2 was semi-ambulatory with a walker.<br><br>Review of Resident #2's record revealed no documentation of written notice of discharge.<br><br>Telephone interview with Resident #2 on 03/03/21 at 4:39pm revealed:<br>-She usually had a hard time going to sleep.<br>-She was asleep when she was awakened by staff on the night of 03/02/21 at around 11:30pm.<br>-Staff told her there was not enough staff to work at the facility and she had to move to a different facility.<br>-She did not like getting out of her bed and moving to a different facility, but there was nothing she could do about it. | C 224 | | |

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-She left the facility in her night clothes, her coat, socks, and shoes.
-Staff went back to the facility at some point to get more clothes for her for the next day.

Telephone interview with the Owner on 03/01/21 at 1:15 pm revealed she had given verbal notices of discharge to the resident and family member as of today that the facility would be closing.

Telephone interview with a medication aide (MA) on 03/03/21 at 2:59pm revealed:
-The 3rd shift staff did not show up at the facility.
-Residents were moved to a different facility, under the same ownership, after 11:00pm.
-She was at the other facility when the residents arrived.
-When Resident #2 arrived at the other facility, she was wearing her night clothes, shoes, a coat, and had blankets and a pillow with her.
-Resident #2 asked why she was getting moved, and she told her it was because a staff did not show up for work.

Telephone interview with a second MA on 03/03/21 at 4:10pm revealed:
-Resident #2's blanket, oxygen, and cell phone bag were with her when she was taken to the other facility under the same ownership.
-Resident #2's 6:00am medications were taken to the facility, but no other scheduled or as needed medications because the residents were supposed to move back to the facility the first thing on the morning of 03/04/21.

Refer to telephone interview with the facility licensed practical nurse (LPN) on 03/03/21 at 9:10am.

Refer to the telephone interview with the Owner

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| C 224 | Continued From page 7<br>on 03/03/21 at 11:49am.<br><br>Refer to the telephone interview with a Supervisor on 03/03/21 at 12:21pm.<br><br>Refer to the telephone interview with a MA on 03/03/21 at 3:56pm.<br><br>Refer to the telephone interview with a second MA on 03/03/21 at 4:10pm.<br><br>Refer to the telephone interview with the Owner on 03/03/21 at 03:30pm.<br><br>2. Review of Resident #3's current FL2 date 11/09/20 revealed:<br>-Diagnoses included dementia with behaviors, major depressive disorder, anxiety, insomnia, hyperlipidemia, and history of gout.<br>-Resident #3 was intermittently confused and was semi-ambulatory with a walker.<br><br>Review of Resident #3's record revealed no documentation of written notice of discharge.<br><br>Telephone interview with Resident #3 on 03/04/21 at 11:30am revealed:<br>-He was in bed asleep when staff woke him up on 03/02/21.<br>-He did not know what was going on when he was awakened.<br>-He did not know why he had to move to a different facility.<br>-He thought the residents were being moved to be bigger house.<br>-"We have to do what we have to do."<br><br>Telephone interview with the Owner on 03/01/21 at 1:15 pm revealed she had given verbal notices of discharge to the resident and family member | C 224 | | |

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| C 224 | Continued From page 8<br>as of today that the facility would be closing.<br><br>Telephone interview with Resident 3's family member on 03/03/21 at 1:54pm revealed:<br>-He did not know staff did not show up to work 3rd shift on 03/03/21 and he did not know Resident #3 was moved to a different facility.<br>-He received a call from the Owner on 03/02/21 during the day, but he had not received a call from any staff to let him know Resident #3 was moving to a different facility.<br>-He was not surprised Resident #3 had to be moved due to staff not showing up for work because staff were probably trying to find another job due to residents having to leave.<br>-He had received notification Resident #3 would have to move by the end of March 2021, but there was no prior notification Resident #3 would be moving on the night of 03/02/21.<br>-He had not signed any paperwork regarding Resident #3 being moved to another facility on 03/02/21.<br><br>Telephone interview with a medication aide (MA) on 03/03/21 at 2:59pm revealed:<br>-The 3rd shift staff did not show up at the facility on 03/02/21.<br>-Residents were moved to a different facility, under the same ownership, on 03/02/21 after 11:00pm.<br>-She was at the other facility when the residents arrived.<br>-When Resident #3 arrived at the other facility, he was wearing his night clothes and bedroom shoes. No other personal items were brought with him.<br>-Resident #3 did not ask any questions about why he was being moved to a different facility.<br><br>Telephone interview with a second MA on | C 224 | | |

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| C 224 | Continued From page 9<br><br>03/03/21 at 4:10pm revealed:<br>-When Resident #3 was awakened from his sleep on 03/02/21 during 3rd shift, he thought the facility was on fire.<br>-Resident #3 was moved to the other facility wearing his night clothes and did not take anything with him.<br>-No scheduled or as needed medications were taken to the other facility because Resident #3 did not have medications scheduled until 8:00am or 9:00am on 03/03/21.<br><br>Refer to the telephone interview with the facility licensed practical nurse (LPN) on 03/03/21 at 9:10am.<br><br>Refer to the telephone interview with the Owner on 03/03/21 at 11:49am.<br><br>Refer to the telephone interview with a Supervisor on 03/03/21 at 12:21pm.<br><br>Refer to the telephone interview with a MA on 03/03/21 at 3:56pm.<br><br>Refer to the telephone interview with a second MA on 03/03/21 at 4:10pm.<br><br>Refer to the telephone interview with the Owner on 03/03/21 at 03:30pm.<br><br>_____<br>Telephone interview with the facility's licensed practical nurse (LPN) on 03/03/21 at 9:10am revealed:<br>-Staff scheduled to work on 3rd shift on 03/02/21 at the facility did not show up.<br>-Residents were moved from the facility to a different facility, under the same ownership, after staff did not show up. | C 224 | | |

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| C 224 | Continued From page 10<br><br>Telephone interview with the Owner on 03/03/21 at 11:49am revealed:<br>-Staff did not call in to work on 03/02/21 and did not show up.<br>-She directed staff to move residents from the facility to another facility under the same ownership after staff did not show up to work.<br>-She did not reach out to anyone for guidance when staff did not show up for 3rd shift work on 03/02/21 except for her licensure attorney.<br>-Her licensure attorney advised her to go ahead and move the residents to another facility under the same license for the safety of the residents.<br><br>Telephone interview with a Supervisor on 03/03/21 at 12:21pm revealed:<br>-Staff did not show up for 3rd shift at the facility on 03/02/21 and the residents had to be moved to a different facility under the same ownership.<br>-Residents were asleep, but they were awakened to move.<br>-The residents moved to the other facility while still in their night clothes.<br>-The residents were told they were moving to the other facility just for the night, but the resident had not returned to the facility as of 03/03/21.<br>-"They were confused, but they understood."<br>-There was no paperwork sent with residents on 03/02/21 when they moved to the different facility.<br>-She did not know if anyone contacted the residents' family members.<br>Telephone interview with a MA on 03/03/21 at 3:56pm revealed:<br>-She was working as a floating MA between the facilities under the same ownership on the morning of 03/03/21.<br>-When she arrived at the facility residents were moved to, the residents' night-time medications were in bags sitting on top of the medication cart.<br>-She had to go to the previous facility to pull the | C 224 | | |

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residents' morning and afternoon medications.
-Residents had not moved back to their facility on as of 03/03/21 at 3:56pm.

Telephone interview with a second MA on 03/03/21 at 4:10pm revealed:
-She was scheduled to work from 10:45pm until 7:00am on 03/02/21 at the facility where residents were moved to.
-No staff showed up for work on 3rd shift at the current facility.
-She called the Owner and the Owner told her to take the 2 residents to a different facility under the same ownership.
-Both residents had on their night clothes and were in bed asleep prior to being moved to the other facility.
-Both residents were startled, confused, and were asking what was going on.
-There was no paperwork brought to the facility with residents on the night of 03/02/21.
-She did not know if anyone contacted the resident's family members.

Telephone interview with the Owner on 03/03/21 at 3:30 pm revealed:
-The Administrator resigned on 03/01/21 and she currently did not have a primary care provider for the residents and had made the decision to close the facility on 03/01/21.
-She was trying to get the residents moved emergently because staff did not show up to work on third shift last night on 03/02/21.
-She did not know what to do about staffing because staff were not showing up to work.
-The only thing she could do at the time was to move the residents to a sister facility because there was no staff to work at the facility.
-She could not fill in for staff because of the court order so the only thing she could do was to move

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| C 224 | Continued From page 12<br>the residents when third shift staff did not show up for work.<br>-The county representative from DSS told her not move the residents because of the Suspension of Admissions (SOA) dated 11/03/20.<br>-She knew moving the residents to the sister facility was against the SOA.<br>-She did not try to call replacement staff in to work because staff did not call her back and ignored her telephone calls.<br>-She had not discussed with staff of her decision to close the facility because then, staff would not show up to work.<br>-She thought staff had heard from "someone" that the facility was closing and just did not show up for work.<br><br>Review of license information for the facility residents were moved to revealed:<br>-The facility was under Licensure Action and a Suspension of Admissions was in place (facility was not allowed to admit new residents).<br>-The facility had ongoing rule violations including Infection Prevention and Control Program, and Management and Other Staff.<br><br>_____<br>The facility failed to ensure a safe and orderly discharge for residents who were awakened out of their sleep and were not informed of the discharge to another facility prior to the discharge; including a resident who was semi-ambulatory with a walker and had diagnoses of hip replacements and vasculittis (Resident #2); and a resident who was intermittently disoriented, had diagnoses of dementia and anxiety, and was semi-ambulatory with a walker (Resident #3). The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. | C 224 | | |

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| C 224 | Continued From page 13<br>_____<br>The facility failed to provide an adequate plan of protection in accordance with G.S. 131D-34 on 03/03/21 for this violation. | C 224 | | |
| C 246 | 10A NCAC 13G .0902(b) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled resident received healthcare referral and follow-up services related to physician's orders for a podiatry consult, a physical therapy consult, and a wound care consult (Resident #1).<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 11/09/20 revealed:<br>-Diagnoses included vascular dementia, hypertension, ataxia, osteoporosis, Meniere disease, and acute respiratory failure.<br>-Resident #1 was non-ambulatory and used a wheelchair.<br><br>1. Review of the facility's previous (started November 2020) Primary Care Provider's (PCP) progress note dated 12/08/20 revealed:<br>-Resident #1 was assessed on 12/08/20 and presented with dislodgement of her right great toenail.<br>-Staff reported damage to Resident #1's right | C 246 | | |

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great toe.
-On exam, Resident #1's right great toenail was thickened, yellow, and appeared to be detaching from the nail bed.
-There was a physician's order for a podiatry consult for the right great toenail fungus and detachment.

Review of Resident #1's record revealed:
-There was no documentation Resident #1 was seen by a podiatrist.
-Resident #1 passed away on 01/20/21.

Interview with a personal care aide (PCA) on 03/01/21 at 10:36am revealed:
-Resident #1's toenails needed to be clipped prior to her death.
-Resident #1's toenails were thick, but she was not sure if they had fungus.
-She had not seen a podiatrist come into the facility and Resident #1 did not go out of the facility to see a podiatrist.

Interview with a Supervisor on 03/01/21 at 10:58am revealed:
-Resident #1's toenails were thick, discolored, and needed to be cut.
-She told the previous Registered Nurse (RN) for the facility Resident #1 needed podiatry care.
-The previous RN was responsible for following up with physician's orders.
-Resident #1 did not have podiatry care prior to her death on 01/20/21.

Interview with another PCA on 03/01/21 at 4:12pm revealed:
-"Resident #1's feet were bad."
-Resident #1's toenails were discolored, thick, crumbling, and falling off.
-She never saw anyone come to the facility to

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provide podiatry care.
-She told the medication aides (MA) Resident #1 need her toenails trimmed and she thought the MAs let the previous facility nurse know.

Telephone interview with a representative in the referrals department at Resident #1's previous (prior to November 2020) PCP's office on 03/02/21 at 12:21pm revealed:
-The previous PCP no longer provided services to the facility effective 10/23/20.
-Resident #1 received podiatry services through the previous (prior to November 2020) PCP group.
-Resident #1 received podiatry care on 05/21/20 and there was documentation there was thickening and discoloration with pain in Resident #1's toenails.
-Resident #1 refused podiatry care on 07/23/20 and 10/17/20.
-The podiatry provider recommended Resident #1 be seen every 2 months for podiatry care.

Telephone interview with the previous RN for the facility on 03/03/21 at 10:42am revealed:
-Resident #1 needed podiatry care.
-Resident #1's big toenail looked like it was trying to come off and needed to be removed.
-The Owner said she would schedule podiatry service for the residents.
-Anytime there was conversation about anything related to nursing, the Owner had to be involved.
-She asked the Owner if she had gotten in touch with a podiatrist and the Owner told her she was working on it.
-Resident #1 did not receive podiatry care between 12/08/20, when the physician's order was written, and her death on 01/20/21.

Interview with the Owner on 03/01/21 at 3:51pm

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| C 246 | Continued From page 16<br>revealed:<br>-None of the residents had seen a podiatrist since the previous facility medical group stopped providing services to residents in October 2020.<br>-"I would say all the residents need to see a podiatrist."<br>-The facility had been waiting on the current medical group to provide podiatry services to residents.<br><br>Attempted contact with the previous (started November 2020) PCP on 03/03/21 at 4:31pm was unsuccessful.<br><br>Attempted contact with Resident #1's family member on 03/04/20 at 9:21am was unsuccessful.<br><br>2. Review of Resident #1's previous (started November 2020) PCP's progress notes dated 01/05/21 revealed:<br>-One of the presenting problems of the visit was a decubitus ulcer.<br>-Resident #1 recently developed a decubitus ulcer to her buttocks/sacral area.<br>-The area was being covered with a hydrocolloid dressing every 3 days (A hydrocolloid dressing provides a moist and insulating healing environment which protect wounds while allowing the body' sown enzymes to heap heal the wounds).<br>-The previous week, the dressing had been removed and coated with a barrier cream.<br>-Removal of the barrier cream led to stripping of new epithelial tissue from the wound.<br>-The hydrocolloid dressing was in place during the visit on 01/05/21 and the wound appeared to be healing again.<br>-There was an order for a wound care consult. | C 246 | | |

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Review of Resident #1's physician's order dated 01/05/21 revealed:
-There was an order for a wound care consult for sacral and heel redness.
-On the order, to the side, was documentation "cancelled, area healed."
-There was no documentation who wrote "cancelled, area healed" and no date when it documented.

Review of Resident #1's record revealed:
-There was no documentation Resident #1 was seen by a wound specialist.
-Resident #1 passed away on 01/20/21.

Interview with a Supervisor on 03/01/21 at 10:58am revealed:
-Resident #1 had a wound on her buttocks smaller than her pinky nail.
-The previous RN for the facility said she could take care of the wound.
-She was pretty sure Resident #1 had an appointment to see a wound specialist, but it was scheduled for a few days prior to her death and the appointment was cancelled.
-The previous RN was responsible for following up with physician's orders

Interview with a personal care aide (PCA) on 03/01/21 at 4:12pm revealed:
-Resident #1 had 2 open sores on her buttocks about the size of the point of an ink pen.
-Staff was putting cream on Resident #1's buttocks, but they had to stop because of the 2 sores.
-Resident #1 did not go to her wound care appointment.
-The previous facility PCP wanted her to go to see a wound care specialist, but the areas were so small, the previous RN stated she did not need

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| C 246 | Continued From page 18<br>to go.<br><br>Telephone interview with the previous RN for the facility on 03/03/21 at 10:42am revealed:<br>-The previous PCP wanted Resident #1 to see a wound specialist because she had a stage 2 wound on her sacral area.<br>-She did not know why "cancelled" was written on the order for the wound care consult or who wrote "cancelled" on the order.<br>-If she had gotten a verbal order and wrote on the original order "cancelled," she would have dated and initialed the verbal order to cancel the wound care consult.<br>-The Owner made the appointments for wound care and she did not know whether the appointment had been scheduled or not after the physician's order for a wound care consult dated 01/05/21.<br><br>Telephone interview with the wound care provider on 03/04/21 at 9:06am revealed:<br>-A referral for a wound care consult for Resident #1 was received on 01/08/21.<br>-The physician's order for the wound care consult was dated 01/05/21.<br>-An appointment was scheduled for 01/12/21 and the appointment was documented as a "No Show."<br>-The facility was contacted on 01/12/21 to reschedule the appointment for the wound care consult and the appointment was rescheduled for 01/18/21.<br>-The facility called to cancel the appointment on 01/18/21 and stated hospice had been called in to care for Resident #1.<br><br>Review of Resident #1's physician's order dated 01/20/21 revealed there was no physician's order for hospice services until 01/20/21. | C 246 | | |

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| C 246 | Continued From page 19<br><br>Interview with the Owner on 03/01/21 at 3:51pm revealed the previous RN for the facility would have been responsible for following up with physician's orders.<br><br>Attempted interview with the previous PCP on 03/03/21 at 4:31pm was unsuccessful.<br><br>Attempted interview with Resident #1's family member on 03/04/20 at 9:21am was unsuccessful.<br><br>3. Review of Resident #1's previous (started November 2020) physician's orders dated 12/22/20 revealed an order for a physical therapy (PT) consult for transfers and gait training.<br><br>Review of Resident #1's record revealed:<br>-There was no documentation Resident #1 was received physical therapy.<br>-Resident #1 passed away on 01/20/21.<br><br>Interview with a personal care aide (PCA) on 03/01/21 at 10:36am revealed:<br>-She needed assistance with getting Resident #1 in and out of her bed and in and out of her wheelchair.<br>-Resident #1 was unsteady on her feet when transferring.<br>-She had not seen a physical therapist come into the facility to work with Resident #1.<br><br>Interview with a Supervisor on 03/01/21 at 10:58am revealed:<br>-She did not know Resident #1 had physician's orders for PT.<br>-Resident #1 required 2 staff to assist with transfers and Resident #1 had difficulty with | C 246 | | |

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standing and pivoting.
-The previous RN for the facilty was responsible for following up with physician's orders.

Interview with the facility's home health office assistant on 03/02/21 at 10:13am revealed:
-The home health agency had not received the physician's order for PT dated 12/22/20.
-The last time Resident #1 was open for PT services was in March 2020.

Interview with the previous RN for the facility on 03/03/21 at 10:42am revealed:
-The previous PCP wrote an order for PT because Resident #1 was having problems with standing.
-She made a copy of the order for PT and gave it to the previous Business Office Manager (BOM) to give to the Owner.
-She was going to call a PT provider, but the Owner told her she would handle scheduling services with a PT provider.
-The Owner never shared information with her regarding what agency the facility used as a home health provider for PT.
-The Owner never gave her the authority to make any PT appointments.
-She did not know if Resident #1 received PT services because there was no documentation of PT and no one ever told her Resident #1 received PT services.

Interview with the Owner on 03/01/21 at 3:51pm revealed:
-She did not know Resident #1 had a physician's order for PT.
-The RN was responsible for following up with physician's orders.

Attempted interview with the previous PCP on

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| C 246 | Continued From page 21<br>03/03/21 at 4:31pm was unsuccessful.<br><br>Attempted interview with Resident #1's family member on 03/04/20 at 9:21am was unsuccessful.<br><br>_____<br>The facility failed to ensure primary referral and follow-up for a resident with physician's orders for a podiatry consult due to a thickened, yellow, detaching toenail; a wound care consult due to a decubitus ulcer to the buttocks/sacral area; and a physical therapy consult for transfers and gait training (Resident #1). This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation.<br><br>_____<br>The facility failed to provide an adequate plan of protection in accordance with G.S. 131D-34 on 03/01/21 for this violation. | C 246 | | |
| C 249 | 10A NCAC 13G .0902(c)(3)(4) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure weights were completed and documented as ordered for 1 of 1 sampled resident (Resident #1) with orders to check weight bi-monthly and weekly. | C 249 | | |

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| C 249 | Continued From page 22<br><br>Review of Resident #1's current FL2 dated 11/09/20 revealed:<br>-Diagnoses included vascular dementia, hypertension, ataxia, osteoporosis, Meniere disease, and acute respiratory failure.<br>-Resident #1 was non-ambulatory and used a wheelchair.<br><br>Review of Resident #1's physician's orders dated 11/09/20 revealed an order to check Resident #1's weight on the 1st and 15th of the month.<br><br>Review of a physician's order dated 12/29/20 revealed an order to check Resident #1's weight every week.<br><br>Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2020 revealed:<br>-There was an entry for weights check on the 1st and 15th of the month.<br>-Resident #1's weight was documented on 11/01/20 as 160.<br>-There was no documentation Resident #1's weight was checked on 11/15/20.<br><br>Review of Resident #1's eMAR for December 2020 revealed:<br>-There was an entry for weights check on the 1st and 15th of the month.<br>-Thee was not an entry to check weights every week.<br>-There was no documentation Resident #1's weight was checked on 12/01/20 or 12/15/20 or weekly in December 2020.<br><br>Review of Resident #1's eMAR for January 2020 revealed:<br>-There was an entry for weights check on the 1st | C 249 | | |

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and 15th of the month.
-There was not an entry to check weights ever week.
-There was no documentation Resident #1's weight was checked on 12/01/20 or 12/15/20 or weekly in January 2021..

Telephone interview with a medication aide (MA) on 03/04/21 at 11:14am revealed:
-The facility nurse helped with weighing residents on the 1st and the 15th of each month because some staff did not know how to weigh residents and sometimes -the scales were not calibrated.
-Personal care aides (PCA) and MAs were responsible for weighing residents and then sending a picture of the weights to the facility nurse.
-The facility nurse was responsible for entering the resident's weight on the eMAR and MAs were not allowed to enter weights.

Telephone interview with a Supervisor on 03/04/21 at 12:21pm revealed:
-All residents had physician's orders for weights on the 1st and 15th of every month.
-PCAs and MAs were responsible for obtaining residents' weights.
-Weights were usually taken on 1st shift, but if 1st shift did not have time, 2nd shift would take residents' weights.
-The list of residents' weights was texted to the facility nurse and the facility nurse was responsible for documenting the weights on the eMAR.
-She did not know Resident #1 had physician's orders for weekly weights.

Telephone interview with a MA/PCA on 03/04/21 at 2:35pm revealed:
-A seated scale was used to weigh residents at

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| C 249 | Continued From page 24<br>the facility.<br>-Some staff could not read the scale and would wait on a floater or a 2nd shift staff to come in to weigh residents.<br>-Residents' weights were sent to the facility nurse via text and she was responsible for documenting the weights on the eMAR.<br>-She did not know if all staff obtained residents' weights on the 1st and 15th of the month, but she did.<br>-She had seen weights not being documented for residents, but she had not said anything to the facility nurse.<br><br>Telephone interview with the previous registered nurse (RN) for the facility on 03/03/21 at 10:42am revealed:<br>-PCAs and MAs were responsible for taking bi-monthly weights for residents and reporting the weights to her.<br>-Once she received the weights from staff, she kept a log of resident weights in a notebook in the office.<br>-The previous facility primary care provider (PCP) ordered weekly weights for Resident #1.<br>-She thought staff were taking Resident #1's weights weekly as ordered.<br>-Staff told her once in January 2021 that Resident #1 refused to get out of bed to be weighed.<br><br>Interview with the Owner on 03/01/21 at 3:51pm revealed if a resident had orders for weights, the weights should have been documented on the eMAR. | C 249 | | |
| C 311 | 10A NCAC 13G .0909 Residents' Rights<br><br>10A NCAC 13G .0909 Resident Rights<br>A family care home shall assure that the rights of | C 311 | | |

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| THE LYMAN HOUSE | 900 KENREED DR THOMASVILLE, NC 27360 |

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| C 311 | Continued From page 25<br>all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>TYPE A1 VIOLATION<br><br>Based on record reviews and interviews the facility neglected to ensure each resident was treated with respect and dignity related to residents being woken out of their sleep and transported to another facility without prior knowledge (Resident #2 and #3).<br><br>The findings are:<br><br>Review of the facility census revealed there was a census of 2 residents.<br><br>Interview with the Owner on 03/01/21 at 11:30am revealed:<br>-Less then "one hour ago" she decided that she was closing the facility today.<br>-The facility did not have an Administrator.<br>-The Administrator submitted his resignation today, 03/01/21.<br>-There was no contracted nurse at the facility and she had no one in charge.<br>-The Supervisors were to handle everything until the last resident moved out of the facility.<br>-She was not allowed in the facility where the residents' lived.<br>-She was getting ready to call all the residents' families, responsible parties and guardians to have them come to the facility and pick up the residents today.<br>-She had not given the residents' a notice of discharge.<br>-She had not contacted the local County Department of Social Services to inform them of | C 311 | | |

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| C 311 | Continued From page 26 | C 311 | | |

her plan to close the facility.

1. Review of Resident #2's current FL2 dated 11/09/20 revealed:
-Diagnoses included end stage renal disease (dialysis), anemia, type II diabetes mellitus, thrombocytopenia, vasculittis, right hip replacement, left hip replacement.
-Resident #2 was semi-ambulatory with a walker.

Telephone interview with Resident #2 on 03/03/21 at 4:39pm revealed:
-She usually had a hard time going to sleep.
-She was asleep when she was awakened by staff on the night of 03/02/21 at around 11:30pm.
-Staff told her there was not enough staff to work at the facility and she had to move to a different facility.
-She did not like getting out of her bed and moving to a different facility, but there was nothing she could do about it.
-She left the facility in her night clothes, her coat, socks, and shoes.
-Staff went back to the facility at some point to get more clothes for her for the next day.

Telephone interview with Resident #2's family member on 03/03/21 at 1:32pm revealed:
-He was aware Resident #2 was moved to a different facility on 03/02/21.
-He did not wish to answer any additional questions.

Telephone interview with a medication aide on 03/03/21 at 2:59pm revealed:
-The 3rd shift staff did not show up at the facility on 03/02/21.
-Residents were moved to a different facility, under the same ownership, on 03/02/21 after 11:00pm.

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| C 311 | Continued From page 27 | C 311 | | |

-She was at the other facility when the residents arrived.
-When Resident #2 arrived at the other facility, she was wearing her night clothes, shoes, a coat, and had blankets and a pillow with her.
-Resident #2 asked why she was getting moved, and she told her it was because a staff did not show up for work.

Telephone interview with a second MA on 03/03/21 at 4:10pm revealed:
-Resident #2's blanket, oxygen, and cell phone bag were with her when she was taken to the other facility under the same ownership.
-Resident #2's 6:00am medications were taken to the facility, but no other scheduled or as needed medications.

Refer to the telephone interview with the facility licensed practical nurse (LPN) on 03/03/21 at 9:10am.

Refer to the telephone interview with the Owner on 03/03/21 at 11:49am

Refer to the telephone interview with a Supervisor on 03/03/21 at 12:21pm.

Refer to the telephone interview with a second MA on 03/03/21 at 4:10pm.

Refer to the telephone interview with the Owner on 03/03/21 at 3:30pm.

2. Review of Resident #3's current FL2 dated 11/09/2 revealed:
-Diagnoses included dementia with behaviors, major depressive disorder, anxiety, insomnia, hyperlipidemia, and history of gout.
-Resident #3 was intermittently confused and was

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| C 311 | Continued From page 28<br>semi-ambulatory with a walker.<br><br>Telephone interview with Resident #3 on 03/04/21 at 11:30am revealed:<br>-He was in bed asleep when staff woke him up on 03/02/21.<br>-He did not know what was going on when he was awakened.<br>-He did not know why he had to move to a different facility.<br>-He thought the residents were being moved to be bigger house.<br>-"We have to do what we have to do."<br><br>Telephone interview with Resident 3's family member on 03/03/21 at 1:54pm revealed:<br>-He did not know staff did not show up to work 3rd shift on 03/03/21 and he did not know Resident #3 was moved to a different facility.<br>-He received a call from the Owner on 03/02/21 during the day, but he had not received a call from any staff to let him know Resident #3 was moving to a different facility.<br>-He was not surprised Resident #3 had to be moved due to staff not showing up for work because staff were probably trying to find another job due to residents having to leave.<br><br>Telephone interview with a medication aide (MA) on 03/03/21 at 2:59pm revealed:<br>-The 3rd shift staff did not show up at the facility on 03/02/21.<br>-Residents were moved to a different facility, under the same ownership, after 11:00pm.<br>-She was at the other facility when the residents arrived.<br>-When Resident #3 arrived at the other facility, he was wearing his night clothes and bedroom shoes. No other personal items were brought with him. | C 311 | | |

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| C 311 | Continued From page 29<br>-Resident #3 did not ask any questions about why he was being moved to a different facility.<br><br>Telephone interview with a second MA on 03/03/21 at 4:10pm revealed:<br>-When Resident #3 was awakened from his sleep on 03/02/21 during 3rd shift, he thought the facility was on fire.<br>-Resident #3 was moved to the other facility wearing his night clothes and did not take anything with him.<br>-No scheduled or as needed medications were taken to the other facility because Resident #3 did not have medications scheduled until 8:00am or 9:00am on 03/03/21.<br><br>Refer to telephone interview with the facility licensed practical nurse (LPN) on 03/03/21 at 9:10am.<br><br>Refer to the telephone interview with the Owner on 03/03/21 at 11:49am<br><br>Refer to the telephone interview with a Supervisor on 03/03/21 at 12:21pm.<br><br>Refer to the telephone interview with a second MA on 03/03/21 at 4:10pm.<br><br>Refer to the telephone interview with the Owner on 03/03/21 at 3:30pm.<br><br>_____<br>Telephone interview with the facility licensed practical nurse (LPN) on 03/03/21 at 9:10am revealed:<br>-Staff scheduled to work on 3rd shift on 03/02/21 at the facility did not show up.<br>-Residents were moved from the facility to a different facility, under the same ownership, after staff did not show up. | C 311 | | |

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| C 311 | Continued From page 30<br><br>Telephone interview with the Owner on 03/03/21 at 11:49am revealed:<br>-Staff did not call in to work on 03/02/21 and did not show up.<br>-She directed staff to move residents from the facility to another facility under the same ownership after staff did not show up to work.<br>-She did not reach out to anyone for guidance when staff did not show up for 3rd shift work on 03/02/21 except for her licensure attorney.<br>-Her licensure attorney advised her to go ahead and move the residents to another facility under the same license for the safety of the residents.<br><br>Telephone with a Supervisor on 03/03/21 at 12:21pm revealed:<br>-Staff did not show up for third shift at the facility on 03/02/21 and the residents had to be moved to a different facility under the same ownership.<br>-Residents were asleep, but they were awakened to move.<br>-The residents moved to the other facility while still in their night clothes.<br>-The residents were told they were moving to the other facility just for the night, but the resident had not returned to the facility as of 03/03/21.<br>-"They were confused, but they understood."<br><br>Telephone interview with a second MA on 03/03/21 at 4:10pm revealed:<br>-She was scheduled to work from 10:45pm until 7:00am on 03/02/21 at the facility where residents were moved.<br>-No staff showed up for work on 3rd shift at the current facility.<br>-She called the Owner and the Owner told her to take the 2 residents to a different facility under the same ownership.<br>-Both residents had on their night clothes and | C 311 | | |

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| C 311 | Continued From page 31 | C 311 | | |

were in bed asleep prior to being moved to the other facility.
-Both residents were startled, confused, and were asking what was going on.

Telephone interview with the Owner on 03/03/21 at 3:30 am revealed:
-She was trying to get the residents moved emergently on 03/02/21 because staff did not show up to work on third shift last night.
-She did not know what to do about staffing because staff were not showing up to work.
-The only thing she could do at the time was to move the residents to a sister facility because there was no staff to work at the facility.
-The county representative from DSS told her not move the residents because of the Suspension of Admissions (SOA) dated 11/03/20.
-She knew moving the residents to the sister facility was against the SOA.
-She was no longer certified to provide resident care services, so she could not assist with providing care to the residents until staff replacements were found.
-She told the staff in the facility to move the residents beginning around 10:45pm on 03/02/21 to the sister facility because their replacement staff was not arriving to work third shift from 11:00pm-7:00am.
-She moved the residents because she did not want them to be left alone in the middle of the night without caregivers.
-She made numerous attempts to obtain staff replacements for the staff who quit beginning on 03/01/21.
-She did not try to call replacement staff to work third shift on 03/02/21 because staff did not call her back and ignored her telephone calls.
-She had not discussed with staff of her decision to close the facility because then, staff would not

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| C 311 | Continued From page 32<br>show up to work.<br>-She thought staff had heard from "someone" that the facility was closing and just did not show up for work.<br><br>Review of license information for the facility residents were moved to revealed:<br>-The facility was under Licensure Action and a Suspension of Admissions was in place (facility was not allowed to admit new residents).<br>-The facility had ongoing rule violations including Infection Prevention and Control Program, and Management and Other Staff.<br><br>_____<br>The facility neglected to ensure the residents (Residents #2 and #3) were treated with respect and dignity by failing to ensure qualified staff were at the facility during each shift to care for the residents. Residents were awakened out of their sleep after 11:00pm on third shift because there was no staff available to work and moved to another facility that was under a SOA Licensure Action. The Owner was aware of the possibility staff would not show up to work and did not attempted to call staff to work third shift. The residents did not receive any notification they were going to be moved. This resulted in the residents being confused about why they were being moved, residents being away from their home and personal belongs and residents not having all their medications available to them. This failure of the facility resulted in serious neglect of the residents' health, safety, and welfare which constitutes a Type A1 Violation.<br><br>_____<br>The facility failed to provide a plan of protection in accordance with G.S. 131D-34 on 03/03/21 for this violation. | C 311 | | |

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| C 912 | Continued From page 33 | C 912 | | |
| C 912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Management and Other Staffing, Health Care and Discharge of Residents.<br><br>The findings are:<br><br>1. Based on record reviews and interviews, the facility failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each resident's rights as evidenced by the failure to maintain substantial compliance with the rules and statues governing adult care homes related to residents' rights, discharge of residents, and health care. [Refer to Tag 0185, 10A NCAC 13G .0601(a) Management (Type A1 Violation)].<br><br>2. Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled resident received healthcare referral and follow-up services related to physician's orders for a podiatry consult, a physical therapy consult, and a wound care consult (Resident #1). [Refer to Tag 0246, 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. | C 912 | | |

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| C 912 | Continued From page 34<br><br>3. Based on record review and interviews, the facility failed to ensure a safe and orderly discharge for 2 of 2 sampled residents (Resident #2 and #3). [Refer to Tag 0224, 10A NCAC 13G .0705 Discharge of Residents (Type B Violation)]. | C 912 | | |
| C 914 | G.S 131D-21(4) Declaration Of Resident's Rights<br><br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, interviews and observations, the facility failed to assure each resident was free of neglect related to residents' rights.<br><br>The findings are:<br><br>Based on record reviews and interviews the facility neglected to ensure each resident was treated with respect and dignity related to residents being woken out of their sleep and transported to another facility without prior knowledge (Resident #2 and #3). [Refer to Tag 0311, 10A NCAC 13G .0909 Residents' Rights (Type A1 Violation)]. | C 914 | | |