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C 000	Initial Comments The Adult Care Licensure Section complaint investigation on 03/01/21-03/04/21 with an exit conference via telephone on 03/04/21.	C 000		
C 015	10A NCAC 13G .0214 Suspension of Admissions 10A NCAC 13G .0214 Suspension of Admissions (a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include: (1) the period of the suspension, (2) factual allegations, (3) citation of statutes and rules alleged to be violated, (4) notice of the facility's right to contested case hearing or the suspension. (b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents. (c) The home shall not admit new residents during the effective date of the suspension. (d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected. This Rule is not met as evidenced by: TYPE B VIOLATION	C 015		

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C 015	Continued From page 1 Based on observations and interviews, the facility failed to comply with the Suspension of Admissions issued by the Adult Care Licensure Section on 11/03/20 by moving two additional residents from another facility who were not identified by facility management as current residents of the facility or residents prior to the notification of the Suspension of Admissions. The findings are: The Division of Health Service Regulation (DHSR) issued a Suspension of Admissions (SOA) on 11/08/20, which was sent via certified mail. Observation on 03/01/21 at 9:30am during the initial tour of the facility revealed: -There were three bed rooms in the facility. -Bedroom #1 had a single bed and one resident. -Bedroom #2 had two twin beds and one resident. -Bedroom #3 had two twin beds and one resident. Interview with the Owner on 03/03/21 at 9:40am revealed: -She received the Suspension of Admissions notification by certified letter in November 2020. -She asked the management of DHSR if she could move residents from one facility to the other facility on 03/01/21. -The management team informed her this was not an option because of the SOA on 11/03/20. -She asked a county representative from the Division of Social Services (DSS) on 03/02/21. -The county representative from DSS told her not move the residents because of the SOA on 11/03/20. -She decided to move the residents from a sister facility to the facility because staff failed to call and no show for their scheduled third shift.	C 015		

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C 015	Continued From page 2 -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 knew moving the residents to the facility was against the SOA. -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 told the staff in the sister facility to move the residents beginning around 10:45pm on 03/02/21 to the facility because their replacement staff was not arriving to work third shift from 11:00pm-7:00am. Telephone interview with the facility's Licensed Practical Nurse (LPN) on 03/03/21 at 9:15am revealed: -Two residents from another facility were moved from the facility where they resided into the facility around 10:45pm according to the report she received from a Supervisor in Charge (SIC) present on second shift last night (03/02/21). -The residents were moved into the facility because there were three staff that did not show up for the third shift (11:00pm-7:00am). -The staff at facility did not contact her to inform her that three staff did not show up for third shift. _____ The facility failed to ensure a safe and orderly admission of two residents violating a suspension of admissions provided by the Adult Care Licensure Section on 11/03/20. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	C 015		

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C 015	Continued From page 3 The facility failed to provide an adequate plan of protection in accordance with G.S. 131D-34 on 03/01/21, and 03/04/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 19, 2021.	C 015		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care	C 185		

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homes as related to Health Care, Food and Nutrition, and Admissions of residents.

The findings are:

Interview with the Owner on 03/02/21 at 12:30pm revealed:
-She was not allowed to perform the Administrator's responsibilities of the management of the day to day operations of the facility involving the residents' needs because she no longer had an Administrator's license.
-Her Administrator license had been suspended in July 2020 and she was no longer able to be involved with the daily operations of the facility.
-The Administrator quit yesterday (03/01/21) after surveyors arrived on site.
-She planned to close the facility because she was tired of the ongoing harassment from the state.
-She did not care anymore and asked that the surveyors' findings be wrote up.
-She was no longer keeping the facility open and it no longer mattered what happened.

Interview with a resident's Responsible Party (RP) on 03/04/21 at 10:45am revealed:
-During a visit with the resident from the porch, to celebrate his birthday in January 2021, looking into the facility through the screen door, she noticed the resident was very lethargic, non-verbal, and not responding to her.
-The Supervisors in Charges (SICs) and personal care aides (PCAs) did their best to answer her questions about what changes had taken place with the resident's medication, but the staff could not answer all her questions.
-The SICs could not provide a telephone number to reach the resident's Nurse Practitioner or the facility's Registered Nurse (RN).

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C 185	Continued From page 5 -The facility's RN present between 01/13/21-01/19/21 told the SIC to inform her the resident would have a visit with the Nurse Practitioner. -She called the Owner and was only able to leave a voice message about her concerns about the resident. -She telephoned the Owner and left a voice message because she did not know how to contact the Administrator in January 2021 but did not get a return call from the Owner. -She had never spoken to the Administrator since he became the Administrator in July 2020. -When she called the facility, the telephone call went to a voicemail box and when she would get a response, it was the Owner who returned her telephone call. -She received a return call from the SIC when the resident was sent to the hospital on 02/21/21. -No one, including the Owner, responded to her telephone messages until her family member recently needed to be sent to the hospital on 02/21/21. Interview with a Supervisor in charge (SIC) on 03/01/21 at 11:00am revealed: -She did not go to the Administrator with any concerns about the residents because, when she went to the Administrator, the Owner intervened and provided feedback or solutions to her concerns. -She last saw the Administrator in the facility two weeks ago. -The Administrator did not come into the facility every day. -The Owner did not come into the facility when she worked her shift to check on the residents and ask questions. -There were two different facility RNs who quit since the beginning of February 2021.	C 185		

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C 185	Continued From page 6 -The facility's Licensed Practical Nurse (LPN) started working at the facility the last week of February 2021. -The facility's LPN was at the facility on Mondays, Wednesdays, and Fridays. -The facility's LPN told her to write communication notes to the facility's LPN about residents' concerns or changes in conditions. -The residents' nurse communication notes were collected at the end of the month by the third shift SIC and taken to the business office. -The facility's LPN did not come to the facility to follow up on the communication notes she wrote on the residents. Interview with another SIC on 03/02/21 at 3:30pm revealed: -The Administrator did not visit the facility during second shift to check on the residents and staff. -She was told by another SIC to write communication notes to the facility LPN daily and make sure the personal care aides (PCAs) completed the shift care notes on each resident and sign them. -She had not met the facility's LPN who started the last week of February 2021. -The Owner did not visit the facility, but she called her with any concerns about the residents. Telephone interview with the Administrator on 03/01/21 at 2:41pm revealed: -He was "supposed to be" responsible for the overall management of the facility. -He allowed the Owner to use his Administrator license to allow the facility to remain open. -He was not consulted about the changes of the facility Nurse Practitioner and Facility Nurse. -The Owner maintained contacts with the facility Nurse Practitioner and facility LPN.	C 185		

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C 185	Continued From page 7 Non-compliance was identified in the following rule areas: 1. Based on interviews and record reviews, the facility failed to ensure the Nurse Practitioner was notified related to 3 of 3 sampled residents with neurological changes leading to a hospitalization (Resident #3), residents with unobtainable weights (Residents #1, #2, & #3), and a missed anxiety medication for a resident (Resident #2). [Refer to Tag C0246, 10A NCAC 13G .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations and interviews, the facility failed to comply with the Suspension of Admissions issued by the Adult Care Licensure Section on 11/08/20 by moving two additional residents from another facility who were not identified by facility management as current residents of the facility or residents prior to the notification of the Suspension of Admissions. [Refer to Tag C0015, 10A NCAC 13G .0214(c) Suspension of Admissions (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure documentation of facility contacts with the residents' Nurse Practitioner, regarding resident care were maintained in the residents' records for 3 of 3 sampled residents (Residents #1, #2, #3). [Refer to Tag C0015, 10A NCAC 13G .0902(c)(1) Health Care (Standard Deficiency)]. 4. Based on observations and interviews the facility failed to ensure food being stored in the kitchen refrigerator was protected from contamination related to expired food items not being discarded. [Refer to Tag C0257, 10A NCAC 13G. 0904(a)(2) Food and Nutrition (Standard Deficiency)].	C 185		

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C 185	Continued From page 8 5. Based on observations, interviews, and record reviews the facility failed to ensure there was at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets for 3 residents residing in the facility. [Refer to Tag C0259, 10A NCAC 13G. 0904(a)(4) Food Procurement and Nutrition (Standard Deficiency)]. 6. Based on observations, interviews and record reviews, the facility failed to ensure menus were prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements. [Refer to Tag C0264, 10A NCAC 13G. 0904(c)(1) Food and Nutrition (Standard Deficiency)]. 7. Based on observations, interviews, and record reviews, the facility failed to offer or make snacks available three times a day. [Refer to Tag C0272, 10A NCAC 13G. 0904(d)(2) Food and Nutrition (Standard Deficiency)]. 8. Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 sampled residents with an order for a nutritional supplement three times daily (Residents #1, #2, & #3) and a resident with physician's orders for honey thickened liquids (Resident #2). [Refer to Tag C0284, 10A NCAC 13G. 0904(e)(4) Therapeutic Diets in Family Care Homes (Standard Deficiency)]. _____ The facility failed to ensure the management, operations, and policies and procedures of the facility were implemented to ensure follow up with primary care provider for neurological	C 185		

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C 185	Continued From page 9 changes in Resident #3 that were not addressed, leading to hospitalization, a twenty one pound weight loss and twelve doses of missed anxiety mediations for Resident #2, documentation of contacts with the residents primary care provider, serving a diet as ordered, food storage supply and having menus available for nutritional guidance. This failure placed the residents at risk for serious physical harm or neglect and constitutes an A2 Violation. _____ The facility failed to provide an adequate plan of protection in accordance with G.S. 131D-34 on 03/01/21, and 03/04/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 4, 2021.	C 185		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure the Nurse Practitioner was notified related to 3 of 3 sampled residents with neurological changes leading to a hospitalization (Resident #3), residents with unobtainable weights (Residents #1, #2, & #3), and a missed anxiety medication for a resident (Resident #2). The findings are:	C 246		

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C 246	Continued From page 10 1. Review of Resident #3's current FL2 dated 11/09/20 revealed diagnoses included dementia with behaviors and traumatic subdural hemorrhage. Telephone interview with Resident #3's responsible party (RP) on 03/04/21 at 11:30am revealed: -She visited Resident #3 daily in January 2021 for his birthday the week of 01/13/21-01/19/21. -Resident #3 was not his talkative self and was slow to respond to questions in conversation she made with him. -On 01/19/21 she visited Resident #3 on the porch before she departed to return home and touched Resident #3's knee. -On 01/19/21 she found Resident #3's knee to be very boney as if he had lost a considerable amount of weight since she visited 4-5 weeks earlier. -The Supervisor in Charge (SIC) during her visits that week told her Resident #3 was not eating the meals provided by them. -She told the SIC that Resident #3 was getting too many medications because he was not himself. -The SIC told her that she would communicate her concerns to the facility Registered Nurse (RN) or the Owner during her visits the week of 01/13/21-01/19/21. -She left voice messages for the Owner to return her telephone call because she wanted to speak to the facility's RN or Resident #3's Nurse Practitioner (NP) the week of 01/13/21-01/19/21. -She did not get a return telephone call from the Owner. -Another one of Resident #3's family members visited Resident #3 weekly in the month of February 2021. -Resident #3's family member told her the Owner	C 246		

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had to find another NP in January 2021 and in the beginning of February the facility RN left her employment with the facility.
-On 02/18/21 during a virtual visit with Resident #3 was too lethargic to hold his head up and speak, so she contacted the family member who lived close to the facility to go visit Resident #3.
-She was contacted by the SIC on 02/21/21 that Resident #3's oxygen levels had dropped and Resident #3 needed to go to the hospital.
-When Resident #3 was hospitalized 02/21/21-02/28/21 she visited Resident #3.
-During her visits at the hospital Resident #3 had a significant amount of weight loss and a pressure ulcer was found on his coccyx.
-Resident #3 passed away at the hospital on 02/28/21.

Telephone interview with Resident #3's family member on 03/04/21 at 3:30pm revealed:
-She visited Resident #3 almost every week since the beginning of January 2021.
-She would visit Resident #3 on the porch through the screen door.
-Since the beginning of January 2021 Resident #3 began to present more lethargic and aphasic.
-On 02/20/21 when she visited Resident #3, he was sitting in his wheelchair and was not able to hold his head up; his eyes were shut, and his mouth was open.
-She was concerned that Resident #3 was over medicated with an anti-psychotic and asked to speak to Resident #3's NP or the facility's Licensed Practical Nurse (LPN).
-Staff told her to speak to the Owner because the facility's LPN was not available, and the facility LPN would need to reach out to the NP.
-She called the Owner and left a voicemail.
-On 02/21/21, Resident #3's RP received a telephone from the facility that Resident #3's

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C 246	Continued From page 12 oxygen level dropped, and he was going to the hospital. Telephone interview with the Supervisor in Charge (SIC) on 03/04/21 at 12:45pm revealed: -Resident #3 started becoming sleepier and losing his appetite sometime in January 2021. -She told the facility RN the second week of January 2021 about these changes with Resident #3. -At that time, the Owner was attempting to find another physician to see the residents because the NP had stopped seeing residents the first week of January 2021. -The facility RN told her when they found another physician to see Resident #3, she would have them look at Resident #3's medications. -The current NP began seeing Resident #3 the first week of February 2021 -The current facility LPN started the last week of February 2021 and works part time at the facility. -She had not seen the facility LPN visit Resident #3, but she spoke to the facility LPN on the phone the weekend of 02/21/21 when Resident #3 was sent to the hospital. Telephone interview with the facility LPN on 03/03/21 at 9:30am revealed: -The first time she assessed Resident #3 was on 02/18/21 when the Owner brought it to her attention Resident #3 was not eating and becoming very lethargic. -On 02/19/21, she sent a text message to Resident #3's NP but did not get a response. -On 02/21/21, she received a telephone call from the Owner that Resident #3's oxygen level was "very low". -On 02/21/21, she instructed the staff to send Resident #3 to the hospital.	C 246		

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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
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Telephone interview with Resident #3's NP on 03/04/21 at 9:20am revealed:
-His initial visit with Resident #3 was on 02/02/21.
-He last visited Resident #3 on 02/16/21.
-This was the third visit he made to see Resident #3.
-He did not know Resident #3 was experiencing any neurological changes.
-He was not notified Resident #3 began experiencing neurological changes on 02/21/21 that caused Resident #3 to be sent to the hospital.

2. Review of Resident #1's current FL2 dated 11/09/20 revealed diagnoses included dementia, Parkinson's disease, hypertension, neuropathy, and skin cancer.

Review of Resident #1's physician orders dated 11/08/21 revealed an order to obtain weights on the first and the fifteenth of the month.

Review of Resident #1's December 2020 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain Resident #1's weights on the first and fifteenth of the month.
-On 12/01/20, and 12/15/20 there was no documentation of Resident #1's weight and no reason documented why Resident #1's weight was not checked.

Review of Resident #1's January 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain Resident #1's weights on the first and fifteenth of the month.
-On 01/01/21, and 01/15/21 there was no documentation of Resident #1's weight and no reason documented why Resident #1's weight

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C 246	Continued From page 14 was not checked. Review of Resident #1's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry to obtain Resident #1's weights on the first and fifteenth of the month. -On 02/01/21 there was no documentation of Resident #1's weight and no reason documented why Resident #1's weight was not checked. -On 02/15/21 there was documentation Resident #1's weight was 124 pounds. Interview with the Supervisor in Charge (SIC) on 03/01/21 at 11:00am revealed: -She did not weigh Resident #1 because the chair scale "was not working" and Resident #1 was combative at times. -There was not a facility Registered Nurse (RN) available in the facility during January 2021 and February 2021 to tell she was not able to obtain Resident #1's weight. -The facility RN was responsible for communicating with the Nurse Practitioner if they could not get Resident #1's weight. Interview with another SIC on 03/02/21 at 3:30pm revealed: -She successfully obtained Resident #1's weight on 02/15/21 but was not able to get Resident #1 to agree again to be weighed using the chair scale. -There was not a facility RN who was available to address Resident #1's weight. -She was told by the Owner to report these types of issues to the facility RN. Interview with Resident #1's Nurse Practitioner (NP) on 03/04/21 at 9:20am revealed: -His initial visit with Resident #1 was on 02/02/21.	C 246		

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C 246	Continued From page 15 -He last visited Resident #1 on 02/23/21. -This was the third visit he made to see Resident #1. -He did not know Resident #1 was not being weighed twice a month. -He was not notified Resident #1's was difficult to obtain because she was combative at times or the facility chair scale was not working. -He expected to be made aware of these types of problems. -Resident #1 was at risk for inadequate nutritional intake which could lead to skin breakdown or changes in her behaviors. Additional documentation of the resident's provider visits, progress notes, and nurse's notes were requested and not provided prior to exit of the facility on 03/04/21. Attempted telephone interview with the facility Licensed Practical Nurse (LPN) on 03/04/21 at 10:00am was unsuccessful. Refer to telephone interview with the Administrator on 03/01/21 at 2:30pm. Refer to interview with the Owner on 03/02/21 at 12:21pm. b. Review of Resident #2's current FL2 dated 11/09/20 revealed diagnoses included Huntington's disease and migraines. Review of Resident #2's physician orders dated 11/08/21 revealed an order to obtain weights on the first and the fifteenth of the month. Observation of the facility's scale used to obtain the Resident #2's weight on 03/01/21 at 11:00am revealed Resident #2's weight was 108 pounds.	C 246		

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C 246	Continued From page 16 Review of Resident #2's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry to obtain Resident #2's weights on the first and fifteenth of the month. -On 12/01/20 there was no documentation for Resident #2's weight and no reason documented why Resident #1's weight was not checked. -On 12/15/20 Resident #2's weight was documented as 120 pounds. Review of Resident #2's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry to obtain Resident #2's weight on the first and fifteenth of the month. -On 01/01/21, and 01/15/21 there was no documentation for Resident #2's weight and no reason documented why Resident #2's weight was not checked. Review of Resident #2's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry to obtain Resident #2's weight on the first and fifteenth of the month. -On 2/01/21 there was no documentation for Resident #2's weight and no reason documented why Resident #2's weight was not checked. -On 2/15/21 Resident #2's weight was documented as 129 pounds. Interview with the Supervisor in Charge (SIC) on 03/01/21 at 11:00am revealed: -She did not weigh Resident #2 because the chair scale was "not working". -There was not a facility Registered Nurse (RN) in January 2021 and February 2021 to contact related to inability to obtain Resident #2's weight.	C 246		

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C 246	Continued From page 17 -The facility RN was responsible for communicating with the Nurse Practitioner if they could not get Resident #2's weight. Interview with another SIC on 03/02/21 at 3:30pm revealed: -She successfully obtained Resident #2's weight on 02/15/21. -She was told the scale was not accurate by the facility RN in January 2021. -When she weighed Resident #2 in February 2021 according to the chair scale Resident #2 gained some weight. -She did not know Resident #2 now weighed 108 pounds. Interview with Resident #2's Nurse Practitioner (NP) on 03/04/21 at 9:20am revealed: -His initial visit with Resident #2 was on 02/02/21. -He last visited Resident #2 on 02/23/21. -This was the third visit he made to see Resident #2. -He did not know Resident #2 was not being weighed twice a month. -He did not know the facility scales were broken or if Resident #2 had gained or lost any weight. -He expected to be made aware of these types of problems. Additional documentation of the resident's provider visits, progress notes, and nurse's notes were requested and not provided prior to exit of the facility on 03/04/21. Attempted telephone interview with the facility Licensed Practical Nurse (LPN) on 03/04/21 at 10:00am was unsuccessful. Refer to telephone interview with the Administrator on 03/01/21 at 2:30pm.	C 246		

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C 246	Continued From page 18 Refer to interview with the Owner on 03/02/21 at 12:21pm. c. Review of Resident #3's current FL2 dated 11/09/20 revealed diagnoses included dementia with behaviors and traumatic subdural hemorrhage. Review of Resident #3's physician orders dated 11/08/21 revealed an order to obtain weights on the first and the fifteenth of the month. Review of Resident #3's December 2020 electronic medication administration record (eMAR) revealed: -There was an entry to obtain Resident #3's weight on the first and fifteenth of the month. -On 12/01/20, and 12/15/20 there was no documentation of Resident #3's weight and no reason documented why Resident #3's weight was not checked. Review of Resident #3's January 2021 electronic medication administration record (eMAR) revealed: -There was an entry to obtain Resident #3's weights on the first and fifteenth of the month. -On 01/01/21, and 01/15/21 there was no documentation of Resident #3's weight and no reason documented why Resident #3's weight was not checked. Review of Resident #3's February 2021 electronic medication administration record (eMAR) revealed: -There was an entry to obtain Resident #3's weights on the first and fifteenth of the month. -On 2/01/21 there was no documentation for Resident #3's weight and no reason documented	C 246		

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C 246	Continued From page 19 why Resident #3's weight was not checked. -On 2/15/21 Resident #3's weight was documented as 120 pounds. Telephone interview with Resident #3's responsible party (RP) on 03/04/21 at 11:30am revealed: -She visited Resident #3 daily in January 2021 and for his birthday the week of 01/13/21-01/19/21. -Resident #3 was not his talkative self and was slow to respond to questions in conversation she made with him. -She visited on the porch before she departed to return home and touched Resident #3's knee. -She found Resident #3's knee to be very boney as if he had lost a considerable amount of weight since she visited 4-5 weeks earlier. -The Supervisor in Charge (SIC) on duty during her visits reported Resident #3 was not eating the meals provided by the facility. Interview with the SIC on 03/01/21 at 11:00am revealed: -She did not weigh Resident #3 because the chair scale was "not working" and Resident #3 was combative at times. -There was not a facility RN in January 2021 and February 2021 to contact regarding inability to obtain Resident #3's weight. -The facility LPN was responsible for communicating with the Nurse Practitioner (NP) if they could not get Resident #3's weight. Interview with another SIC on 03/02/21 at 3:30pm revealed: -She successfully obtained Resident #3's weight on 02/15/21 but she was not able to get Resident #3 to agree to get on the chair scale to be weighed.	C 246		

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C 246	Continued From page 20 -She did not tell the facility RN because since December 2020 there was not a facility RN who was available to contact regarding Resident #3's weight. -She was told by the Owner to report these types of issues to the facility RN. Interview with Resident #3's NP on 03/04/21 at 9:20am revealed: -His initial visit with Resident #3 was on 02/02/21. -He last visited Resident #3 on 02/23/21. -This was the third visit he made to see Resident #3. -He did not know Resident #3 was not being weighed twice a month. -He was not notified Resident # 3 was difficult to get his weight because he was combative at times or the facility chair scale was not working. -He expected to be made aware of these types of problems. -Resident #3 was at risk for inadequate nutritional intake which could lead to skin breakdown or changes in his behaviors. Additional documentation of the resident's provider visits, progress notes, and nurse's notes were requested and not provided prior to exit of the facility on 03/04/21. Attempted telephone interview with the facility LPN on 03/04/21 at 10:00am was unsuccessful. Refer to telephone interview with the Administrator on 03/01/21 at 2:30pm. Refer to interview with the Owner on 03/02/21 at 12:21pm. Telephone interview with the Administrator on 03/01/21 at 2:30pm revealed:	C 246		

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-He resigned today (03/01/21), after a conversation he had between him and the Owner led him to the decision to quit.
-He done his best to help the Owner with the day to day operations of the facility but felt he was not successful.
-He expected the Facility Nurse and the residents' Nurse Practitioner to be aware of all the residents' needs concerning changes in their condition, or weight gains or losses.
-He worked a full-time job and could not keep up with the changes made by the Owner with the contracted health care providers.

Interview with the Owner on 03/02/21 at 12:21pm revealed:
-The facility nurses were responsible for contacting legal guardians and the Nurse Practitioner involving the health care needs of the residents.
-The current facility LPN started two weeks ago.
-The Administrator resigned today (03/01/21).
-She was not allowed by court order to go inside the facilities.
-She did not know why the residents' primary care providers were not notified when there was a change in a resident condition, and residents' weights weren't being completed.

3. Review of Resident #2's current FL2 dated 11/09/20 revealed:
-Diagnoses included Huntington's disease and migraines.
-There was an order for lorazepam (used to treat anxiety) 1mg every 8 hours.

Review of Resident #2's January 2021 electronic medication administration record (eMAR) on 03/01/21 revealed:
-There was an entry for lorazepam 1 mg every 8

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hours.
-Lorazepam 1 mg was scheduled for administration at 6:00am, 2:00pm and 10:00pm daily.
-Lorazepam 1 mg was documented as administered at 6:00am, 2:00pm, and 10:00am daily from 01/29/21 to 01/31/21.

Review of Resident #2's February 2021 eMAR revealed:
-There was an entry for lorazepam 1 mg every 8 hours.
-Lorazepam 1 mg was scheduled for administration at 6:00 am, 2:00 pm and 10:00pm daily.
-Lorazepam 1 mg was documented as administered from 02/01/21 to 02/28/21 at 2:00pm (last dose administered).
-Lorazepam 1 mg was documented as not administered on 02/28/21 at 10:00pm "waiting on meds [medication], Nurse notified".

Review of Resident #2's March 2021 eMAR revealed:
-There was an entry for lorazepam 1 mg every 8 hours.
-Lorazepam 1 mg was scheduled for administration at 6:00am, 2:00pm and 10:00pm daily.
-Lorazepam 1 mg was documented as not administered from 03/01/21 at 6:00am through 03/02/21 at 2:00pm.
-The reason for not administered was documented as "waiting on meds [medication], Nurse notified".

Review of Resident #2's Controlled Substance Count Sheet (CSCS) dated 01/29/21 revealed:
-There were 90 tablets of lorazepam documented on the CSCS as received on 01/29/21.

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C 246	Continued From page 23 -Lorazepam 1 mg was signed out on the CSCS 3 times a day from 01/29/21 at 8:38 pm through 02/28/21 at 2:00 pm for a total of 90 doses. Observation of medications on hand for administration to Resident #2 on 03/01/21 at 10:30 am and 03/02/21 at 4:00 pm revealed: -There was no lorazepam 1mg available for administration to Resident #2 in the medication cart. -There was an empty bingo card labeled lorazepam 1mg one tablet every 8 hours with a dispense date of 01/29/21 for 90 tablets and all tablets had been punched from the bingo card. Interview with the day shift medication aide (MA) on 03/01/21 at 11:20 am revealed: -The facility's Registered Nurse (RN) left in early February 2021. -There was a part-time facility Licensed Practical Nurse (LPN) helping at the facility 2 or 3 days a week. -She was not able to administer Resident #3's lorazepam 1mg on 03/01/21 because the medication was not available. -The facility LPN was at the facility on 02/28/21 but did not have the medication from the pharmacy delivery on 02/26/21. -She was told by one of the other MA the facility LPN was informed Resident #2 did not have any lorazepam available. -The MA had not notified the resident's primary care provider(PCP) because the MAs had been instructed not to text or fax the PCP themselves by the facility's Owner. Attempted telephone interview with the Administrator on 03/01/21 and 03/02/21 was unsuccessful.	C 246		

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C 246	Continued From page 24 Interview with the Owner on 03/01/21 at 4:00 pm revealed the facility LPN was responsible for all medications. Telephone interview with the facility LPN on 03/01/21 at 8:30 am revealed: -She placed overstock of medications with CSCS tracking logs in a locked medication cart in the Nurse's office at the facility's office. -There were no overstock-controlled medications in the LPN's office for Resident #2. Telephone interview with a representative at the contracted pharmacy on 03/02/21 at 2:55 pm revealed: -The pharmacy dispensed 90 lorazepam 1mg for Resident #2 on 01/29/21. -There were no additional orders for lorazepam 1mg for the resident at the pharmacy. -When the facility sent the pharmacy a request for the refill of a medication that required a refill order the pharmacy routinely sent a notification in the drug delivery tote sent from the pharmacy. -The notification from the pharmacy that a refill order was required was delivered in the delivery tote from the pharmacy with medications when they were delivered the next day. -The facility was responsible for contacting the PCP to request refills. -The pharmacy occasionally contacted a PCP to request a refill for a resident's medication, but this facility had changed their contract PCP and the pharmacy was not sure who the contact for a refill. -There was no documentation the facility contacted with the pharmacy for additional information related to Resident #2's lorazepam. Interview with the second shift MA on 03/02/21 at 4:00 pm revealed:	C 246		

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C 246	Continued From page 25 -Resident #2 did not have lorazepam 1mg on the medication cart to administer on 03/01/21 at 10:00 pm. -She had not notified the resident's PCP because the facility LPN took care of refills now. Interview with another second shift MA on 03/02/21 at 4:12 pm revealed: -The MAs were supposed to inform the facility LPN when a resident had 5 to 10 tablets of a medication remaining. -She had left a message for the facility LPN on 03/01/21 that Resident #2 was out of lorazepam 1mg, but she had not heard back from the facility LPN. -There was a note on the computer screen for the facility LPN dated 02/28/21 (the last day the facility LPN was in the facility) informing the Nurse that Resident #2 was out of lorazepam 1 mg. _____ The facility failed to ensure notification to primary care providers of neurological changes in Resident #3 that were not addressed, leading to a hospitalization, and a 21-pound weight loss and 12 dosed of missed anxiety medication for Resident #2. This failure placed residents in risk for physical harm, and neglect and constitutes a Type A2 Violation. _____ The facility failed to provide an adequate plan of protection in accordance with G.S. 131D-34 on 03/01/21, and 03/04/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 4, 2021.	C 246		

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C 247	10A NCAC 13G .0902(c) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of facility contacts with the residents' Nurse Practitioner, regarding resident care was maintained in the residents' records for 3 of 3 sampled residents (Residents #1, #2, #3). The findings are: 1. Review of Resident #3's current FL2 dated 11/09/20 revealed diagnoses included dementia with behaviors and traumatic subdural hemorrhage. Review of staff communication notes revealed: -There were no communication notes regarding Resident #3's neurological changes, such as slowed response to commands, loss of appetite, combative behaviors, or inability to lift his head and speak. -There were no communication notes regarding staff's inability to obtain Resident #3's weight twice monthly.	C 247		

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C 247	Continued From page 27 -There were no communication notes regarding any contacts with the primary care provider (PCP) for resident complaints and changes in Resident #3's condition that required an emergency room visit on 02/21/21. -There was no documentation Resident #3 was hospitalized from 02/21/21-02/28/21. -There was no documentation Resident #3's appointments with the Nurse Practitioner (NP) . -There was no documentation of the medication and treatment orders written by the NP after January 2021. Refer to interview with the Supervisor in Charge on 03/01/21 at 11:00am. Refer to interview with another Supervisor in Charge on 03/01/21 at 3:30pm. Refer to telephone interview with the facility Licensed Practical Nurse (LPN) on 03/03/21 at 9:15am. Refer to interview with the Owner on 03/03/21 at 12:15pm. 2. Review of Resident #1's current FL2 dated 11/09/20 revealed diagnoses included dementia, Parkinson's disease, hypertension, neuropathy, and skin cancer. Review of staff communication notes revealed: -There were no communication notes regarding staff's inability to obtain Resident #1's weight twice monthly. -There were no communication notes regarding any contacts with the Nurse Practitioner (NP) for Resident #1's complaints and changes in behaviors. -There was no documentation of Resident #1's	C 247		

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C 247	Continued From page 28	C 247		

appointments with the NP.

Refer to interview with the Supervisor in Charge on 03/01/21 at 11:00am.

Refer to interview with another Supervisor in Charge on 03/01/21 at 3:30pm.

Refer to telephone interview with the Facility Nurse on 03/03/21 at 9:15am.

Refer to interview with the Owner on 03/03/21 at 12:15pm.

3. Review of Resident #2's current FL2 dated 11/09/20 revealed diagnoses included Huntington's disease, and migraines.

Review of staff communication notes revealed:
-There were no communication notes regarding staff's inability to obtain Resident #2's weight twice monthly.
-There were no communication notes regarding any contacts with the Nurse Practitioner (NP) for Resident #2's complaints and changes in appetite, unwillingness to be weighed.
-There was no documentation of Resident #2's appointments with the NP since January 2021.

Refer to interview with the Supervisor in Charge on 03/01/21 at 11:00am.

Refer to interview with another Supervisor in Charge on 03/01/21 at 3:30pm.

Refer to telephone interview with the facility Licensed Practical Nurse (LPN) on 03/03/21 at 9:15am.

Refer to interview with the Owner on 03/03/21 at

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C 247	Continued From page 29 12:15pm. _____ Interview with the Supervisor in Charge (SIC) on 03/01/21 at 11:00am revealed: -She did not document communication notes to any of the residents' providers in their records. -She verbally communicated with the Facility Nurse any of the residents' complaints, changes, or behaviors. -The Owner told her the Facility Nurse was responsible for documenting notes to the residents' Nurse Practitioner. Interview with another SIC on 03/01/21 at 3:30pm revealed: -She did not write communication notes in the residents' records. -She was told by another SIC that the facility LPN was supposed to put all the NP orders, visits notes, and write communications notes in the residents' records. Telephone interview with the facility LPN on 03/03/21 at 9:15am revealed: -She would have to locate all the residents' notes with their providers, written orders, and written communications. -She did not know where they were in her office. -When she started two weeks ago, she did not have anyone to show her where these documents were filed. Interview with the Owner on 03/02/21 at 12:21pm revealed: -The facility LPN was responsible for make sure all the resident records were complete. -The current facility LPN started two weeks ago. -The Administrator resigned today (03/01/21). -She was not allowed by court order to go inside the facility LPN's office, and she did not have a	C 247		

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C 247	Continued From page 30 key for the locked door.	C 247		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure food being stored in the kitchen refrigerator was protected from contamination related to expired food items not being discarded. The findings are: Review of the local Environmental Health Sanitation report dated 12/16/19 revealed a demerit score of 7. Observation of the food stored in interior of the refrigerator on 03/01/21 at 10:00am revealed: -There was no thermometer located in the refrigerator indicating the interior temperature. -There was a quart size plastic bag with three dozen small carrots with multiple white-gray colored spots -There was a brown liquid substance on two green bell peppers with multiple brownish-gray colored spots. -There were 2 containers of 32-ounce (oz.) coffee creamer: one container was one-third full, with an expiration date of 02/10/21, the other container was one-half full, with an expiration date of	C 257		

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C 257	Continued From page 31 02/09/21. -There was a half-gallon of milk with an expiration date 02/25/21. -There was a plastic storage container of baked beans with a fuzzy gray substance on top of the beans. -There was a plastic storage bag with deli ham with an expiration date 02/21/21. -There was a package of bologna with an open date of 02/16/21. -There was glass bowl containing two cooked chicken breasts partially covered with foil with no storage date. -There was a plastic storage bag containing 13 slices of dark, black bacon with no label or expiration date. -There were two unshelled, uncooked, raw eggs in a plastic container with no expiration date. Observation of the interior of the freezer on 03/01/21 at 10:15am revealed: -There was no thermometer located in the freezer to indicate the interior temperature. -There was a half galloon ice cream with the lid partially covering the container and no open date. -There were 2 open boxes of toaster waffles with the end of boxes left fold into the boxes; first box had 3 waffles in an open plastic bag (no open date), second box 4 waffles in an open plastic bag (no open date). Interview with the personal care aide (PCA) on 03/01/21 at 10:45am revealed: -She did not know exact dates of when to discard items in the refrigerator or freezer. -She did not know the last time the refrigerator or freezer was cleaned out of expired food. -She never saw a thermometer in the refrigerator or freezer. -She did not receive any formal food service	C 257		

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C 257	Continued From page 32 training since she started working. Interview with the Supervisor in Charge (SIC) on 03/01/21 at 1:30pm revealed: -She never saw a thermometer in the refrigerator or freezer. -She was told by another SIC when she started working to make sure the refrigerator and freezer were checked every 3 days for expired foods. -She had not checked the food in the refrigerator or freezer in the last month. Telephone interview with the Administrator on 03/01/21 at 2:30pm revealed: -He did not check the refrigerator and freezer for expired foods. -He expected the SICs and PCAs to be trained on appropriate food sanitation. -The Owner hired all the staff and ensured they were trained on how to do their jobs. Interview with the Owner on 03/02/21 at 12:21pm revealed she did not know about any food being spoiled and not discarded because she could not go into the facility to inspect them.	C 257		
C 259	10A NCAC 13G .0904(a)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by:	C 259		

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C 259	Continued From page 33 Based on observations, interviews, and record reviews the facility failed to ensure there was at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility, for both regular and therapeutic diets for 3 residents residing in the facility. The findings are: Interview with the personal care aide (PCA) on 03/01/21 at 9:15am revealed there were 3 residents who resided in the facility. Review of 3 of 3 residents' diet orders revealed the 3 residents were ordered a regular diet, and 2 residents were ordered a nutritional supplement 3 times daily. Observation of the kitchen area on 03/01/21 at 9:30am revealed there was no week-at-a-glance menu available. Observation of the food stored in the refrigerator on 03/01/21 at 10:00am revealed there was no perishable foods available to be counted as part of a three-day supply. Observation of the food stored in the kitchen freezer on 03/01/21 at 10:15am revealed: -There was 1 unopened box of toaster waffles. -There was 1 pound of frozen imitation crab meat. -There was 1 pound of frozen shrimp. -There was 1 package of 8 frozen hamburger buns. -There were 4 packages of 8 frozen hot dog buns. -There were 2 boxes of 8 ice cream sandwiches. Observation of the dry storage cabinet of the	C 259		

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facility's kitchen on 03/01/21 at 10:25am revealed:
-There were 4 half gallon bottles of vegetable juice.
-There were 4 twelve-ounce cans of chicken noodle soup.
-There were 4 boxes of lasagna noodles.
-There was 1 box of macaroni and cheese.
-There were 2 half loaves of bread.
-There were 2 bags of opened potato chips.
-There was a box with seven 14-ounce bottles of protein shakes.

Interview with Resident #4 on 03/01/21 at 1:15pm revealed:
-He did not know what he was going to have to eat for breakfast, lunch, or dinner.
-He did not eat breakfast because he did not like what they offered.
-The facility only served him catered meals for lunch and dinner every day.
-He did not know what he was going to eat until the meals were delivered.
-He ate extra servings for lunch and dinner because he was hungry.
-If he was still hungry, he would order a pizza for delivery.

Interview with the personal care aide (PCA) on 03/01/21 at 9:15am revealed:
-She prepared what each resident liked for breakfast with what was available to cook.
-If she ran out of something, she needed to prepare a meal or snack for a resident, she would send a message to the SIC to get it from the food building next to the corporate office.
-The food building and corporate office was located approximately a half mile away.

Interview with the Supervisor in Charge (SIC) on

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C 259	Continued From page 35 03/01/21 at 9:30am revealed: -The personal care aide (PCA) prepared and served breakfast to the residents. -The caterer used to send a weekly menu for lunch and dinner, but she had not seen one in over a month. -She did not keep track of what food was available for the residents. -She would pick up what the PCAs requested from the facility food pantry, refrigerator, or freezer located in a building next to the corporate office. Interview with the Administrator on 03/01/20 at 2:30pm revealed: -The Owner did the purchasing of all the food. -There was a building located next to the corporate office where food was stored. -He did not know there was not enough food supply in the facility. Interview with the Owner on 03/02/21 at 12:21pm revealed: -She did not have time to find food receipts to prove she purchased an adequate amount of food for the residents. -She did not care anymore about whether the residents were getting adequate nutritional meals at this point.	C 259		
C 264	10A NCAC 13G .0904(c)(1) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements in Paragraph (d) of this Rule.	C 264		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure menus were prepared at least one week in advance with serving quantities specified and in accordance with the Daily Food Requirements.

The findings are:

Observation of the kitchen area on 03/01/21 at 9:30am revealed there was no week-at-a-glance menu available.

Observation of the breakfast meal service on 03/01/21 from 9:15am to 10:00am revealed the meal consisted of a chocolate toaster pastry, a toasted waffle, scrambled eggs, a cup of coffee and water.

Observation of the lunch meal service on 03/01/21 from 1:00pm to 2:00pm revealed the meal was purchased from a local restaurant which consisted of fried fish, slaw, and green beans, and a choice of sweet tea or water.

Interview with the personal care aide (PCA) on 03/01/21 at 9:15am revealed:
-She prepared and served breakfast to all the residents.
-There was not a weekly menu posted because she prepared and served only what the residents would eat for breakfast.
-Lunch and dinner were catered from a local diner.

Interview with the Supervisor-in-Charge (SIC) on 03/01/21 at 9:30am revealed:
-She had never seen a weekly menu posted.

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C 264	Continued From page 37 -The personal care aide (PCA) prepared and served breakfast to the residents. Interview with the Administrator on 03/01/20 at 2:30pm revealed: -He had never seen a weekly menu created by the Owner. -The Owner told the staff to only fix the foods the residents liked for breakfast. Interview with the Owner on 03/02/21 at 12:21pm revealed: -She had never created a weekly menu. -She did not care anymore about whether the residents are getting adequate nutritional meals at this point.	C 264		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to offer or make snacks available three times a day. The findings are: Interview with a personal care aide (PCA) on 03/01/21 at 9:15am revealed there were 3	C 272		

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residents who resided in the facility.

Observation of the kitchen area on 03/01/21 at 9:30am revealed there was no week-at-a-glance menu available.

Observations in the facility on 03/01/21 between 9:15am to 4:00pm revealed snacks were not offered or made available to residents.

Interview with a resident on 03/01/21 at 1:15pm revealed:
-He ate extra servings for lunch and dinner because he was hungry.
-If he was still hungry, he would order a pizza for delivery.

Observation of the facility's available snack supplies on 03/01/21 at 11:00am revealed:
-There was one 16 oz. jar of grape jelly.
-There was one 16 oz. jar of apple jelly.
-There were four single serve plastic containers of peaches.
-There were two open bags of potato chips.
-There were two half loaves of bread.

Interview with the Supervisor-In-Charge (SIC) on 03/01/21 at 11:30am revealed:
-If a resident came to her and ask for snacks and she would give them what they had available.
-One resident would order pizza for delivery and ask to eat the leftover for his snack.
-The other two residents were offered their supplements because they did not like what they had available for snack.
-The Owner purchased all the food for snacks and kept them in another building "down the road" next to the corporate office.
-If they needed food from the supply building, she would send a message to another SIC that

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C 272	Continued From page 39 floated between facilities when they were not passing medications or assisting with resident care. -If the "float" SIC was not allowed to leave her duties to bring food, the food was delivered the next shift or the next day. Telephone interview with the Administrator on 03/01/21 at 2:30pm revealed: -The Owner purchased all the food. -The snacks were kept in a building next to the corporate office. -Staff were expected to arrange for enough snacks to be available and served to each resident. Interview with the Owner on 03/02/21 at 12:21pm revealed: -She purchased all the food for the residents. -She did not know if snacks were served.	C 272		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 3 sampled residents with an order for a nutritional supplement three times daily (Residents #1, & #2) and a resident with physician's orders for	C 284		

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C 284	Continued From page 40 honey thickened liquids (Resident #2). The findings are: Observation of the kitchen area on 03/01/21 at 10:00am revealed there was a box with seven 14-ounce bottles of nutritional shakes. 1. Review of Resident #1's current FL2 dated 11/09/20 revealed diagnoses included dementia, Parkinson's disease, hypertension, neuropathy, and skin cancer. Review of Resident #1's physician orders dated 11/08/21 revealed an order for a nutritional shake three times daily between meals. Review of Resident #1's November 2020, December 2020, January 2021, February 2021 eMARs revealed: -There was an entry for a nutritional shake three times daily between meals at 10:00am, 2:00pm and 6:00pm. -There was documentation Resident #1 was administered a nutritional shake three times daily between meals at 10:00am, 2:00pm, and 6:00pm. Observation of the breakfast and lunch meals and snacks on 03/01/21 between 9:15am-3:30pm revealed: -Resident #1 was not served a nutritional shake between the breakfast and lunch meal. -Resident #1 was not served a nutritional shake between the lunch and dinner meal. Refer to interview with the personal care aide (PCA) on 03/01/21 at 10:45am. Refer to interview with the Supervisor in Charge (SIC) on 03/01/21 at 11:30am.	C 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL029012	A. BUILDING: _____ B. WING _____	C 03/04/2021

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C 284	Continued From page 41 Refer to telephone interview with the Administrator on 03/01/21 at 2:30pm. Refer to interview with the Owner on 03/02/21 at 12:21pm. Refer to telephone interview with Resident #1's Nurse Practitioner (NP) on 03/04/21 at 1:30pm. 2. Review of Resident #2's current FL2 dated 11/09/20 revealed diagnoses included Huntington's disease. a. Review of Resident #2's physician orders dated 11/08/21 revealed an order for boost three times daily between meals. Review of Resident #2's November 2020, December 2020, January 2021, February 2021 eMARs revealed: -There was an entry for a nutritional shake three times daily between meals at 10:00am, 2:00pm and 6:00pm. -There was documentation Resident #2 was administered a nutritional shake three times daily between meals at 10:00am, 2:00pm, and 6:00pm. Observation of the breakfast and lunch meals and snacks on 03/01/21 between 9:15am-3:30pm revealed: -Resident #2 was not served a nutritional shake between the breakfast and lunch meal. -Resident #2 was not served a nutritional shake between the lunch and dinner meal. Refer to interview with the personal care aide (PCA) on 03/01/21 at 12:45pm. Refer to interview with the Supervisor in Charge	C 284		

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C 284	Continued From page 42 (SIC) on 03/01/21 at 1:30pm. Refer to telephone interview with the Administrator on 03/01/21 at 2:30pm. Refer to interview with the Owner on 03/02/21 at 12:21pm. b. Review of Resident #2's physician order dated 12/15/20 revealed an order for honey thickened liquids. Review of the label on Resident #2's thicken powder revealed: -The following directions; scoop and level off recommended amount of thicker using the enclosed measuring spoon, add thickener, whisk until dissolved, allow to stand 30 seconds to one minute to achieve desired consistency. -For honey consistency in 8 ounces of water use 8-10 teaspoons. Observation of Resident #2's lunch meal on 03/01/21 at 12:42pm revealed Resident #2 was served water in a twenty-ounce covered tumbler. Interview with the personal care aide (PCA) on 03/01/21 at 12:45pm revealed: -When she thickened Resident #2's water she placed two large scoops (2 Tablespoons) of thicken powder in the Resident #2's twenty-ounce covered tumbler and served it to Resident #2. -She was told by one of the SICs this was the amount of thicken powder to put in Resident #2's water tumbler. -She did not refer to the label on the thicken powder. -She did not know Resident #2 was ordered honey thickened liquids, she was told Resident #2 was ordered a nectar thickened liquids.	C 284		

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C 284	Continued From page 43 Interview with the Supervisor in Charge (SIC) on 03/01/21 at 1:30pm revealed: -She did not know Resident #2 was ordered honey thickened liquids. -She was told by another SIC to put 2 Tablespoons of thickener into Resident #2's twenty-ounces of water in Resident #2's tumbler. Telephone interview with Resident #1's Nurse Practitioner on 03/04/21 at 1:30pm revealed: -Resident #2 was at high risk for aspiration. -If Resident #2 was not getting her liquids thickened to honey consistency, she could develop aspiration pneumonia. _____ Interview with the PCA on 03/01/21 at 10:45am revealed: -She did not know the residents were supposed to get a nutritional shake between meals. -She offered the nutritional shakes in the pantry because the Supervisor in Charge (SIC) told her to give them to the residents. -She offered the nutritional shakes to the residents when they did like what she served them for breakfast or lunch. Telephone interview with the Administrator on 03/01/21 at 2:30pm revealed: -He did not know why the residents were not getting nutritional shakes like the NP ordered three times a day. -The Owner purchased all the food and nutritional shakes for the residents from a local food supplier. Interview with the Owner on 03/02/21 at 12:21pm revealed: -She purchased all the nutritional shakes for the residents.	C 284		

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C 284	Continued From page 44 -She did not know why the residents were not getting nutritional shakes. -She did not have time to get the receipts for the purchase of nutritional shakes for the residents.	C 284		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Health Care, Suspension of Admissions, and Management. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure the Nurse Practitioner was notified related to 3 of 3 sampled residents with neurological changes leading to a hospitalization (Resident #3), residents with unobtainable weights (Residents #1, #2, & #3), and a missed medication for a resident (Resident #2). [Refer to Tag C0246, 10A NCAC 13G .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations and interviews, the facility failed to comply with the Suspension of Admissions issued by the Adult Care Licensure Section on 11/03/20 by moving two additional	C 912		

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C 912	Continued From page 45 residents from another facility who were not identified by facility management as current residents of the facility or residents prior to the notification of the Suspension of Admissions. [Refer to Tag C0015, 10A NCAC 13G .0214(c) Suspension of Admissions (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to Health Care, Food and Nutrition, and Admissions of residents. [Refer to Tag C0185 10A NCAC 13G .0601(a) Management and Other Staff (Type A2 Violation)].	C 912		