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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a complaint investigation, with onsite visit dates of 02/23/21 - 02/25/21, and a telephone exit on 02/26/21. | D 000 | | |
| D 230 | 10A NCAC 13F .0702 (f) Discharge Of Residents<br><br>10A NCAC 13F .0702 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;<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: | D 230 | | |

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(A) the regional long term care ombudsman; and
(B) the protection and advocacy agency established under federal law for persons with disabilities.

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

Based on interviews and record reviews, the facility failed to provide a safe and orderly discharge for 4 of 4 sampled resident (Residents #1,#2, #4, and #5) as evidence by failing to coordinate an appropriate and safe discharge for the resident, who was discharged to a local hotel where no one was able to meet the needs of the resident (#2), a resident displaying suicidal behaviors (#5), a resident who left the facility without transportation to the new placement (#4), and to provide notification or consultation of the discharge to the mental health provider while services were being provided for the resident (#1).

The findings are:

1. Review of Resident #2's current FL-2 dated 07/11/20 revealed:
-Diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), osteoarthritis, seizure disorder, and tobacco abuse.
-There was documentation the resident was constantly disoriented.

Review of Resident #2's record revealed there was no Resident Register.

Review of Resident #2's Adult Care Home Notice of Transfer/Discharge dated 01/04/21 revealed:
-The resident was given an initial notice of

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discharge/transfer due to safety/bullying endangerment to others; intellectual impairment affected by others.
-The date of the discharge/transfer was 02/03/21.
-The planned discharge location was left blank.
-The long-term care ombudsman's address and phone number was not filled-in on the notice.
-The Administrator signed the discharge notice.

Review of Resident #2's progress notes revealed:
-On 01/11/21 at 1:58pm, the resident went up to the supervisor and accused him of hitting him in the ribcage area that morning; the supervisor explained that his bag bumped the resident, the resident responded if it happened again he would kill the supervisor and got in the supervisor's face, the supervisor apologized to Resident #2.
-There was no documentation the primary care provider (PCP) or mental health provider was contacted regarding appropriate placement.

Review of Resident #2's Adult Care Home Notice of Transfer/Discharge dated 01/11/21 revealed:
-The resident was given a second notice of discharge/transfer due to "emergency discharge; safety of resident and staff in the facility is endangered".
-The date of the discharge/transfer was 01/11/21.
-The planned discharge location was left blank.
-The long-term care ombudsman's address and phone number was filled-in on the notice.
-The Administrator signed the discharge notice.

Telephone interview with Resident #2's mental health nurse on 02/23/21 at 8:20am revealed:
-On 01/11/21, Resident #2 called her and stated, "you have to help me, I was told I have to leave".
-On 01/11/21, she tried contacting the Administrator-in-Charge (AIC) to allow Resident #2 to stay at the facility because they had no

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knowledge of Resident #2 being discharged.
-The AIC told her no, Resident #2 could not stay.
-Resident #2 was discharged without notice and to a hotel with no money, food or medicine.
-On 01/11/21, she contacted local law enforcement for help and was denied.
-The Mental Health Provider (MHP) paid for a hotel for the night to give them time to find placement.
-The MHP found placement for Resident #2 the next day and took Resident #2 to the new facility.
-Resident #2's MHP was not contacted prior to the discharge regarding reasons for the discharge or conference with the MHP regarding if the discharge was in Resident #2's best interest.
-She considered the discharge "neglectful", "dangerous" and unsafe for the resident.
-Resident #2 required medication for schizophrenia (an anti-psychotic) and major depressive disorder and without his medications could have increased hallucinations, delusions and effect his behavior adversely.

Interview with the local Ombudsman on 02/24/21 at 4:21pm revealed:
-She had no conversation with the facility regarding the discharge for Resident #2.
-The facility had not contacted her to discuss an appropriate and safe discharge for a resident who was an endangerment.
-Residents had the right appeal a discharge and should expect the resident to have her contact information in case they needed to speak with her about the discharge.

Interview with a Supervisor on 03/02/21 at 1:00pm revealed:
-Residents received a 30-day or 14-day notice from the Administrator when a discharge

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occurred.
-On 01/11/21, he came to work and accidentally bumped Resident #2 with his workbag.
-He apologized to Resident #2 for accidentally bumping into him; however Resident #2 became very upset standing over him, yelling in his face.
-He notified the Administrator who initiated the discharge.
-The Administrator called local law enforcement who talked with the resident.
-The Administrator talked with Resident #2 to discuss where he could go.
-The Administrator instructed him to take the resident wherever he wanted to go.
-He transported the resident to a local hotel, because that's where the resident wanted to go.
-He did not know who paid for the hotel accommodations, but he knew the resident had snacks with him to eat.

Interview with Resident #2 on 02/24/21 at 10:30am revealed:
-At the beginning of January 2021, he was taken to a hotel by the local law enforcement and the Supervisor from the facility.
-The AIC told him that he had to leave because he was written up for "dangerous intellect".
-He notified his MHP and let them know what happened in order to get help.
-The AIC gave him a trash bag to gather his belongings and his medications were given to him by the medication aide (MA).
-He was driven to the motel by the Supervisor and the local law enforcement followed.
-He was left at the motel without food and money and no room at the time.
-He contacted the MHP again and was told that someone would meet him at the motel.
-He felt scared because he thought the AIC would come there and hurt him.

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-The AIC was angry and acted threatening to him.
-He also felt anxious and mad because he did not have money and did not know where he was going to live.
-A staff member from his MHP paid for a hotel room until arrangements could be made at a new facility.
-He said it was hard for him to explain but he still felt scared of the AIC would come to his new place and harm him.

Telephone interview with Resident #2's mental health physician on 02/23/21 at 2:23pm revealed:
-The facility never reached out to him regarding an appropriate discharge for Resident #2.
-Resident #2's level of care was assisted living.
-Resident #2 required supervision and assistance with his medications.
-Resident #2 would not be appropriate to be dropped off at a hotel as he required assisted living level of care.
-If a resident had aggressive behaviors, he would expect the facility to contact the mental health crisis line to discuss behavior and appropriate placement.
-He never received a call from the facility to discuss a change in Resident #2's level of care.
-Resident #2's discharge to a hotel could have caused the resident to be at risk for an error in administering medications, possible legal trouble, or possible hospitalization.
-Resident #2 could have decompensated causing him to display symptoms of paranoia, delusions, anxiety, or violent behavior.

Second telephone interview with Resident #2's mental health physician on 02/26/21 at 11:46am revealed:
-Resident #2 was referred to mental health services by the Administrator in December 2019

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for a higher level of care.
-Resident #2 had a diagnosis of schizophrenia with symptoms of delusions, paranoia, and anxiety.
-Resident #2 had no family members who were involved in his care.
-He did not know where Resident #2 would have ended up if mental health was not involved in his care.
-The MHP was contacted by the resident after he was insurance, who informed he had nowhere else to go and needed assistance with housing.
-The MHP found Resident #2 with no money or food at a local hotel a day after he was discharged.
-The MHP assisted Resident #2 with finding placement at another assisted living facility, got him tested for COVID-19 for admission to another facility, and paid for extra nights for the hotel.
-Resident #2 was delusional and paranoid.
-The facility was his family along with his MHPs and when he was "kicked to the curb", he lost his family causing the feelings of being lost and alone and was at risk for increased depression or anxiety.

Interview with Resident #2's primary care provider (PCP) on 02/25/21 at 9:30am revealed:
-He normally found out about resident discharges after it occurred.
-He would like to be apart of a resident's discharge or be notified that a resident would be leaving.
-It would not be appropriate to discharge Resident #2 to a hotel, as he required assisted living care.
-Resident #2 required assistance with
-He never changed Resident #2's level of care on the FL2.

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| D 230 | Continued From page 7<br><br>Interview with the AIC on 02/24/21 at 4:32pm revealed:<br>-Resident #2 was wrongfully admitted by the previous owners in 2018.<br>-When he and the Administrator took over the facility, he kept the resident; however he had been working to get the resident appropriate placement and had the resident connected with mental health services.<br>-Resident #2 displayed aggressive behavior and on 01/11/21, he had an "altercation" with one staff and Resident #2 threatened the staff.<br>-The morning of 01/11/21, he gave Resident #2 a 30-day discharge notice and informed the resident he had the choice to call the mental health provider or the local shelter.<br>-Later in the day on 01/11/21, he sent staff with a van to pick up Resident #2 to take him where he wanted to go.<br>-Resident #2 refused to go to a shelter; he had $200.00 and wanted to go to a hotel, so staff transported the resident to the local hotel.<br>-Resident #2 was a danger to the facility.<br>-Resident #2 was informed that he called the MHP, however no one showed up, so "he had to make a decision".<br><br>Interview with the Administrator on 02/25/21 at 1:30pm revealed:<br>-Resident #2 was discharged because he was an endangerment to staff.<br>-She communicated the with Adult Home Specialist (AHS) regarding the discharge on 01/11/21, and she was not informed that it was an improper discharge.<br>-Resident #2 was provided a 30-day notice, and other facilities were contacted, but he wanted to go to a hotel.<br>-Resident #2 signed himself out of the facility.<br>-She did not think that she did anything wrong | D 230 | | |

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with how Resident #2 was discharged from the facility.

2. Review of Resident #5's FL-2 dated 02/09/21 revealed:
-Diagnosis included substance use disorder, Asperger's syndrome, and post-traumatic stress disorder.
-The recommended level of care was assisted living.
-The orientation status was not documented.

Review of Resident #5's Resident Register revealed:
-The resident was admitted to the facility on 02/11/21 from an alcohol and drug abuse treatment center.
-The resident was given a notice of discharge on 02/22/21 for threatening to kill himself "because of pills".
-The resident's discharge location was the local hospital.
-The resident "refused to sign" acknowledging the above information was complete and accurate.

Review of Resident #5's progress notes dated 02/22/21 revealed:
-There was a note indicating the resident had been going into the medication room throughout the day asking for medication for anxiety, stating the current medications were not strong enough.
-Staff informed that the resident could see the physician "this week" and the resident declined; the resident informed he needed stronger medication and if staff could not provide he would leave once the supervisor left for the day.
-The supervisor transported the resident to the hospital because he stated he would kill himself.

Interview with the Primary Care Provider (PCP)

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| D 230 | Continued From page 9<br>on 02/25/21 at 9:30am revealed:<br>-He found out about Resident #5's discharge after he was discharged from the facility.<br>-He would like to be notified of any incidents that lead to a discharge prior to the discharge occurring.<br>-If residents were having suicidal thoughts, he would want the resident to be taken to the hospital; but not discharged to the hospital.<br>-He had not changed Resident #5's level of care to hospital.<br><br>Interview with the Administrator on 02/26/21 at 4:30pm revealed:<br>-Resident #5 should have never been admitted to the facility.<br>-Resident #5 was admitted from a detox facility and she was under the impression, the resident was in "good standing".<br>-On 02/22/21, he was seeking medications and stated he was going to kill himself.<br>-The resident was discharged to the hospital for mental health services.<br>-The physician was not contacted to obtain an FL-2 indicating a new level of care.<br>-The resident was not appropriate to live in the facility.<br>-She did not feel that she done anything wrong in discharging the resident to the local hospital.<br><br>Based on observations, interviews and record review revealed Resident #5 was unavailable for interview.<br><br>3. Review of Resident #4's current FL-2 dated 02/11/21 revealed:<br>-Diagnoses included schizophrenia, autistic spectrum disorder, vitamin D deficiency, hyponatremia, tobacco use, and urinary incontinence. | D 230 | | |

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-The recommended level of care was assisted living.
-The orientation status was not documented.

Review of a 14-day Notice form for Resident #4 dated 02/03/21 revealed:
-Resident #4's mental health provider (MHP) found him a new long-term care facility.
-The discharge date was 02/04/21.

Telephone interview with a previous staff on 02/23/21 at 10:09am revealed:
-On or about 02/04/21, she received a phone call from Resident #4 stating that he had been "kicked out to a motel" and was scared he would have no place to live.
-Resident #4 was "panicked acting" so she contacted his MHP.
-The MHP provider picked him up not far from the facility and took him to another facility.

Interview with Resident #4 on 02/24/21 at 9:40am revealed:
-The Administrator-in-Charge (AIC) gave him a 14-day discharge notice on 02/03/21 because he did not want to quit smoking and the AIC made the facility a "no smoking facility" and he wanted to leave.
-He felt threatened by the AIC and the fact the AIC took away all of his smoking privileges, he wanted to move.
-About 10 days after he received the 14-day notice from the AIC, he contacted his MHP because he did not know where he was going to be living.
-The MHP told him another assisted living facility had a bed open and he wanted to leave then so he did not lose the bed.
-He told the AIC about the bed, and the AIC told him, "I don't care if you stay in a motel" so he left

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the facility and did not sign out.
-He contacted a previous employee by using the hallway phone and got her number from a personal care aide (PCA).
-The previous employee called his MHP and they picked him up down the road and took him to the facility.
-The MHP was able to get his records, and belongings from the facility after picking up Resident #4 down the road from the facility.

Telephone interview with Resident #4's mental health physician on 02/23/21 at 2:23pm revealed:
-Resident #4's level of care was assisted living.
-Resident #4 required supervision and assistance with his medications.
-Resident #4 would not be appropriate to leave the facility alone as he required assisted living level of care.
-He never received a call from the facility to discuss a change in Resident #4's level of care.
-Resident #4's discharge to a hotel could have caused the resident to be at risk for an error in administering medications, possible legal trouble, or possible hospitalization.

Telephone interview with the AIC on 02/25/21 at 1:30pm revealed:
-Resident #4 decided to leave the facility on 02/04/21 because he wanted to live in a facility that allowed him to smoke.
-The MHP assisted Resident #4 with finding placement at another facility.
-Resident #4 signed himself out of the facility, but there was no documentation with his signature.
-He thought Resident #4 had a safe discharge.

Telephone interview with the Administrator on 02/26/21 at 4:30pm revealed:
-Resident #4 discharged himself from the facility

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| D 230 | Continued From page 12<br>on 02/04/21.<br>-Resident #4 had a smoking habit and he wanted to move to a facility where he could smoke.<br>-The MHP came to the facility to transport the resident to the new facility on 02/04/21.<br>-She thought Resident #4 had a safe discharge.<br><br>4. Review of Resident #1's current FL2 dated 08/12/20 revealed_<br>-Diagnoses included mild intellectual disability and paranoid schizophrenia.<br>-Resident #1 was intermittently disoriented.<br><br>Review of Resident #1's Resident Register Discharge/Transfer information revealed:<br>-The notice of discharge/transfer section was blank.<br>-The section for whom initiated the discharge/transfer was blank.<br>-The date of discharge/transfer was blank.<br>-The new address was blank.<br>-Resident #1's responsible party signature was blank.<br>-The Administrator, Supervisor or Administrator-in-Charge (AIC) signature for accuracy was blank.<br><br>Telephone interview with a nurse from Resident #1's mental health provider (MHP) on 02/23/21 at 8:20am revealed:<br>-Resident #1 was diagnosed with schizophrenia and was to be seen by his MHP two times a week.<br>-Resident #1 also took a medication for mental/mood disorders such a schizophrenia and required routine lab work to monitor liver functions.<br>-Because of COVID-19 in 2020, the Administrator-in-Charge (AIC) would not allow the MHP on the property. | D 230 | | |

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-She provided a cell phone for Resident #1 to use for visits with the MHP.
-She had not spoken to Resident #1 in a little over a month.
-On 01/24/21, the MHP tried to contact Resident #1 and was informed by the AIC, Resident #1 was no longer at the facility and would not give the address of where Resident #1 was located.
-The AIC refused to give any information regarding Resident #1 including location, or if Resident #1 was being followed by a medical provider or MHP.
-She attempted multiple times to get the information from the AIC but was not successful.
-She wanted to be "assured" Resident #1's mental health services would continue.
-She even tried contacting the police to file a missing persons report, and notified the Department of Social Services (DSS) for assistance.
-She later was informed by the Adult Home Specialist (AHS) Resident #1 was moved to a group home in another city which was also owned by the AIC.
-She attempted a phone call to the group home identified by the AHS and was told Resident #1 did not live there.
-As of 02/23/21, she still did not know of the location of Resident #1 or if he was receiving mental health services.

Interview with the Supervisor on 02/23/21 at 1:05pm revealed:
-Resident #1 was moved to a group home owned by the AIC on 01/27/21.
-He was working that day but did not know who picked Resident #1 up or how he got to the group home.
-He did not do the paperwork for the discharge.
-He did not know if the discharge paperwork was

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completed.
-The Resident Care Coordinator (RCC) who was no longer at the facility was responsible for filling out the discharge paperwork.

Telephone interview with the AIC on 02/24/21 at 11:30am revealed:
-Resident #1 was moved to the group home in January 2021, because Resident #1 did not qualify for the services supplied by the MHP.
-Resident #1 did not qualify for the MH services because "he was not homeless" and "had a diagnoses of Intellectual Developmental Delay (IDD)" which were two disqualifies for services.
-He did not consult with the MHP before moving Resident #1 to the group home because Resident #1 did to qualify for mental health services.
-He did not give the location of Resident #1 to the MHP.
-He considered the move of Resident #1 to be in Resident #1's "best interest".
-The discharge paperwork was not filled out because it was a transfer to his other facility.

Attempted telephone interviews with Resident #1 at the group home on 02/24/21 at 12:30 and 3:30pm were unsuccessful.

Telephone interview with the Administrator on 02/25/21 at 1:45pm revealed:
-She did not know Resident #1 had services through the MHP until a missing persons report was filed with local law enforcement by the MHP.
-According to the AIC, Resident #1 did not qualify for the services provided by the MHP.
-Resident #1 was moved to a group home owned by the AIC in January 2021.
-She did not know if the discharge paperwork was filled out.
-The RCC was responsible for filling out the

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discharge paperwork which included where Resident #1 was moved to.
-She and the AIC were ultimately responsible for completing the discharge paperwork.

Telephone interview with Resident #1's MHP on 02/26/21 at 11:49am revealed:
-When Resident #1 was admitted to the facility and his service in June 2020, Resident #1 had hallucinations.
-Resident #1 would yell at the trees in the back of the facility.
-Resident #1 received visits by the mental health, two times a week and after COVID-19 started somewhere around April 2020, he was not allowed in the facility to see Resident #1.
-He did have a few virtual and telephone visits.
-Resident #1's last visit was on 01/21/21 at 10:40pm for a psychiatric follow-up and evaluation.
-On the 01/21/21 visit, medications were reviewed, labs were ordered and a coordination of care letter was sent to Resident #1's primary care physician (PCP) regarding the need for a new EKG.
-The coordination of care letter to Resident #1's PCP was also to get the PCP's input on Resident #1's medical issues.
-Resident #1 required an antipsychotic medication to treat his schizophrenia and required blood work to check the status of his liver functions because of the medication.
-Resident #1 also required monitoring his heart because of prolonged use of a medication used to treat depression.
-He performed virtual visits for awhile and then those were discontinued by the AIC around December 2020.
-There were a few telephone visits in January 2021.

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| D 230 | Continued From page 16<br>-Resident #1 was moved to the group home with no mental health plan.<br>-He was not consulted about the move and if it was in Resident #1 best interest related to Resident #1's mental health.<br>-He expected the facility to consult with him and have a plan in place that addressed the negative impact of moving Resident #1 abruptly or if the group home was suitable for Resident #1's level of care.<br>-He considered it neglectful and a serious risk to move Resident #1 without consulting the MHP and putting Resident #1 at risk for increased hallucinations and isolation.<br><br>Telephone interview with Resident #1's PCP on 02/25/21 at 10:00am revealed:<br>-It was his understanding Resident #1 was transferred to a group home on 01/29/21 to be closer to family.<br>-He has not seen Resident #1 since a video visit on 11/10/20.<br>-He did not know Resident #1's MHP was not consulted about the transfer.<br>-It was his understanding the AIC would provide "in house" mental health services.<br>-He would prescribe all of the medications for Resident #1 including psychiatric meds.<br>-He expected the AIC to consult the MHP prior to moving Resident #1 related to recommendations and provide mental health services after the move.<br>-In his opinion, he would not have transferred Resident #1 to another facility without consulting the MHP.<br><br>_____<br>The facility failed to provide a safe and orderly discharge for Resident #2 by not coordinating a specific date, time and preparation of discharge for the resident, which resulted in being | D 230 | | |

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| D 230 | Continued From page 17<br>transported by facility staff to a local hotel with limited food, money and no supervision, and oversite for medications, placing the resident at risk for an error in administering his own medications, possible hospitalization for decompensating causing him to display symptoms of paranoia or violent behavior; Resident #4, who had a history of mental and development disorders to discharge himself resulting in the resident leaving the facility by foot without supervision placing him at risk for injury; and transferring Resident #1 to a group home without consulting the MHP and putting him at risk for increased hallucinations and isolation. This failure resulted in the potential for serious risk for harm to the residents which constitutes a Type A2 Violation.<br>_____<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on February 25, 2021.<br><br>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 28, 2021 | D 230 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .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 observations, interviews, and record reviews the facility failed to ensure referral and follow-up with the provider for 3 of 4 sampled | D 273 | | |

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residents (Resident #7, #2, and #6 ) related to not providing notification regarding a fall (#7), aggressive behaviors (#2), and having a lab drawn in a timely manner and notifying the physician of the lab results (#6).

The findings are:

1. Review of Resident #7's current FL2 dated 02/22/21 revealed diagnoses included diabetes mellitus type 2, traumatic brain injury, degenerative joint disease, and deep vein thrombosis.

Observation of Resident #7 on 02/24/21 at 10:35am revealed:
-The resident's left forearm was swollen, dark red, and bruised.
-There were steri-strips on the resident's left forearm.

Interview with Resident #7 on 02/24/21 at 10:35am revealed:
-He was getting ready for bed when he got dizzy and fell.
-He went to the hospital and got his arm treated.
-He felt like his arm was just about healed.
-He could not remember the exact date that he had fallen.
-His left forearm would hurt at times.
-The staff did not provide any care to his arm.
-He tried not to get it wet during showers.
-He did not know when his steri-strips needed to be removed.

Review of Resident #7's progress notes dated 02/14/21 revealed:
-The resident did not want to take a shower due to laceration on arm that was treated with steri-strips at the hospital two nights ago.

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-There was no documentation Resident #7 had a fall on 02/11/21.
-There was no documentation Resident #7's primary care provider (PCP) had been contacted regarding the fall which occurred on 02/11/21.

Review of Resident #7's incident and accident reports revealed there was no incident report documenting Resident #7 had a fall.

Interview with the Resident Care Coordinator (RCC) on 02/24/21 at 10:40am revealed:
-If Resident #7 had notes from the emergency room (ER), it would be in his record.
-She was not working when Resident #7 hit his head, therefore she did not know where the ER report was located.
-The previous RCC was responsible for reviewing the ER report and following instructions.

Review of Resident #7's ER Report dated 02/11/21 revealed:
-The report was faxed to the facility from the local hospital on 02/24/21.
-Resident #7's chief complaint was musculoskeletal due to fall.
-The resident had an x-ray of his left forearm and there was diffuse soft tissue swelling and widening of his joint space.
-The resident was referred for an outpatient Orthopedic appointment due to joint issue and prevent further pain.
-The discharge instructions included washing the forearm after 24 hours and then keep it clean and dressed daily.

Interview with a personal care aide (PCA) on 02/24/21 at 12:18pm revealed:
-She worked the evening Resident #7 fell.
-Resident #7 fell in the hallway after getting his

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medications.
-Resident #7 was bleeding, therefore he went to the ER.
-Since returning from the hospital, the resident complained his left forearm would hurt if he hit it against something.
-She did not provide any care to Resident #7's steri-strips; if care was provided the medication aides (MAs) provided the care.

Interview with a MA on 02/24/21 at 1:04pm revealed:
-She knew Resident #7 fell on 02/11/21.
-The resident had steri-strips; however she used to keep the left forearm wrapped with gauze, but had not wrapped it recently.
-She used her own knowledge regarding her decision to wrap Resident #7's arm.
-There was no order to provide any care to Resident #7's left forearm.
-The resident had a black brace when he came from the hospital; however she did not know how often he was supposed to wear it.
-The RCC was responsible for notifying the PCP know about falls and determine how to further care for residents with steri-strips.

Telephone interview with another MA on 02/25/21 at 8:10pm revealed:
-She worked on 02/11/21 in the evening when Resident #7 fell.
-Resident #7 had "sutures".
-She did not know how to care for the laceration, so she left it alone.
-She had not reached out to the primary care provider (PCP) to determine how to care for Resident #7's forearm,
-The RCC was responsible for communicating with the PCP.
-She did not provide care to Resident #7's

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forearm.

Second interview with the RCC on 02/24/21 at 12:00pm revealed:
-When a resident went to the ER or hospital but they are not admitted, the PCP was not contacted.
-She did not know why the PCP did not have to be contacted.
-When the resident returned from the hospital, the resident would have a follow-up appointment during PCP's next visit to the facility.
-The previous RCC was responsible for ensuring discharge paperwork or ER reports were received when a resident returned from the hospital.
-The previous RCC would have been responsible for reviewing the emergency department report and following instructions.
-The previous RCC was supposed to notify the PCP about the hospitalization and provide the him with the report.
-The previous RCC would have been responsible for ensuring Resident #7's orthopedic referral was initiated.
-Resident #7 had no upcoming appointments with the orthopedic physician.
-She did not know what care Resident #7 was supposed to have done to his forearm.
-She had just returned to the facility as the RCC on 02/19/21.

Telephone interview with the PCP on 02/25/21 at 9:31am revealed:
-He was not aware Resident #7 had a fall on 02/11/21.
-He would want to be notified of any falls and visits to the hospital within 24 hours after the incident occurred.
-He did not know the resident needed to be referred to the orthopedic physician and did not

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know the resident had steri-strips.
-He last saw Resident #7 in the morning on 02/11/21.
-He would have referred the resident to the orthopedic physician and would have provided instruction on how to care for Resident #7's laceration.
-He would need to see Resident #7's forearm to make a recommendation.
-He would have expected staff to obtain discharge paperwork and follow instructions.

Telephone Interview with the Administrator on 02/25/21 at 1:30pm revealed:
-When residents returned to the facility after an ER visit, the RCC was responsible for obtaining the ER report, reviewing and sending to the PCP.
-The RCC should call the PCP and notify of the incident as soon as possible.
-She and the Administrator In-Charge (AIC) took full responsibility of the lack of follow-up to obtain the ER report and notification of the PCP.
-She and the AIC were responsible for overseeing the RCC and ensuring job duties were being fulfilled.

2. Review of the facility's policy for Management of Physical Aggression or Assault by a Resident revealed depending on the severity of the behavior, and based on the circumstances, the facility will report any dangerous behaviors to the resident's physician and or area mental health authority, and implement physician's orders.

Review of Resident #2's current FL-2 dated 07/11/20 revealed diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), osteoarthritis, seizure disorder, and tobacco abuse.

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Review of Resident #2's progress notes revealed:
-On 01/11/21 at 1:58pm, there was documentation, the resident went up to the supervisor and accused him of hitting him in the ribcage area that morning; the supervisor explained that his bag bumped the resident; the resident responded if it happened again he would kill the supervisor and got in the supervisor's face; the supervisor apologized to Resident #2.
-There was no documentation the primary care provider (PCP) or mental health provider (MHP) was contacted to report behaviors.

Interview with a Supervisor on 03/02/21 at 1:00pm revealed:
-On 01/11/21, he came to work and accidentally bumped Resident #2 with his workbag.
-He apologized to Resident #2 for accidentally bumping into him; however Resident #2 became very upset, and stood over him yelling in his face.
-He notified the Administrator on 01/11/21.
-The Administrator called local law enforcement who talked with the resident.
-He did not contact the MHP for Resident #2, becausethe Administrator did not instruct him to call them.
-He followed the Administrator's instructions.
-He would call the MHP when residents displayed aggressive behaviors, but he did not call for Resident #2 because he was not told to call.

Interview with Resident #2's mental health nurse on 02/23/21 at 2:57pm revealed:
-Resident #2 called her on 01/11/21 on the crisis hotline to inform that he was transported by staff at the facility to a local hotel.
-No one from the facility called the crisis hotline to discuss Resident #2's aggressive behaviors and to inquire of possible interventions.
-If the facility had called about the aggressive

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behaviors, she could have reached out to the mental health physician to discuss next steps.

Telephone interview with Resident #2's mental health physician on 02/23/21 at 2:23pm revealed:
-The facility never reached out to him regarding Resident #2's aggressive behaviors on 01/11/21.
-If a resident had aggressive behaviors, he would expect the facility to contact the mental health crisis line immediately to discuss behaviors and develop appropriate interventions.
-He could have gotten the resident in the hospital to be evaluated for medication changes and/or treatment.

Interview with Resident #2's PCP on 02/25/21 at 9:30am revealed:
-He was not aware Resident #2 became aggressive towards one of the staff on 01/11/21.
-He would expect the facility to notify him of aggressive behaviors.
-He could have worked with the mental health physician to develop an intervention to address the behavior.
-Resident #2 could have been sent out to the hospital for a physiological evaluation or treatment.

Interview with the Administrator In-Charge (AIC) on 02/24/21 at 4:32pm revealed:
-Resident #2 displayed aggressive behavior and on 01/11/21, he had an "altercation" with one staff and Resident #2 threatened the staff.
-On 01/11/21, in the morning, he gave Resident #2 a 30-day discharge notice and informed the resident he had the choice to call the mental health provider or the local shelter.
-Resident #2 informed that he called the MHP, but no one showed up.

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Interview with the Administrator on 02/25/21 at 1:30pm revealed:
-Resident #2 called the MHP, no one from the MHP showed up or called.
-The local law enforcement was called to de-escalate the situation.

3. Review of Resident #6's current FL-2 dated 02/22/21 revealed diagnoses included cerebral palsy, neurogenic bladder, schizophrenia, bipolar disorder and hypertension.

Review of Resident #6 incident report dated 12/12/20 at 10:30am revealed:
-Resident #6 was sent to the emergency room for pain, lethargy (lack of energy) and vomiting.
-He was discharged back to the facility with a diagnosis of urinary tract infection and elevated lithium level (lithium is a medication used to treat bipolar disorder, high levels can be toxic).

Review of the hospital discharge summary dated 12/12/20 revealed:
-Resident #6's lithium level was high at 1.8 (normal lithium level 0.6 - 1.2).
-Resident #6 was to have his lithium level redrawn in 1-2 days.

Review of Resident #6's medical record revealed:
-On 12/14/20, the previous Resident Care Coordinator (RCC) requested an order to check Resident #6's lithium level and Resident #6's primary care provider (PCP) signed an order for a lithium level to be drawn on 12/18/20.
-On 12/30/20, the previous RCC again requested an order to check Resident #6's lithium level and the order was signed by the PCP.
-There were no lithium lab results for Resident #6 after he returned from the hospital on 12/12/20.

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Review of Resident #6's lab results revealed:
-There was a lithium lab result for Resident #6 dated 01/26/21.
-The lab result was not initialed as reviewed by the PCP.
-Resident #6's lithium level was low at 0.4 (normal lithium level 0.6 - 1.2).

Interview with the RCC on 02/24/21 at 11:50am revealed:
-She worked for the facility previously, in 2020 but had left.
-She did not have Resident #6's lithium lab results but would call the lab and get the results.
-The residents' lab results were usually faxed to the facility by the lab.
-The PCP reviewed the lab results monthly when he came to the facility.
-If the lab results were out of normal range the RCC notified the PCP by either calling him or faxing the results to him.
-The PCP would initial the lab results after he reviewed them when he came to the facility, usually monthly.

Interview with a representative from the facilitiy's contracted laboratory services on 02/26/21 at 4:01pm revealed from 12/12/20 to 01/26/21, the lab received one request for a lithium level for Resident #6 and it was dated 01/26/21.

Interview with Resident #6's PCP on 02/25/21 at 9:50am revealed:
-He had not seen Resident #6's lab results dated 01/26/21 and the facility had not notified him of the abnormal lithium level.
-The RCC was responsible for ensuring labs were drawn as ordered and to notify him of abnormal results.
-He saw Resident #6 on 02/11/21 and had not

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| D 273 | Continued From page 27<br>seen his lab results.<br>-He initialed all lab results after he reviewed them.<br>-Outcomes of high lithium levels could cause toxicity, uncontrolled movements, vomiting and abdominal pain.<br>-Outcomes of low lithium levels could increase Resident #6's bipolar symptoms.<br><br>Interview with the Administrator on 02/25/21 at 12:45pm revealed:<br>-The RCC was responsible for reviewing hospital discharge paperwork and notifying the resident's PCP of any necessary follow-up.<br>-The RCC was responsible for scheduling resident labs and notifying the PCP of the results.<br>-She recently became aware Resident #6's lab test had not been completed as ordered, but she could not remember when that was.<br>-The RCC employed at the time of Resident #6's discharge on 12/12/20 no longer worked at the facility.<br>-She and the Administrator-in-Charge (AIC) were responsible for overseeing the RCC and ensuring her job duties were fulfilled.<br><br>_____<br>The facility failed to ensure physician notification for 3 of 4 sampled residents as related to Resident #7 who had a fall and was sent to the hospital and had orders for a referral to an orthopedic physician and care instructions for a laceration; Resident #2's mental health provider was not notified of aggressive behaviors resulting in the Administrator discharging the resident into the community at a local hotel without proper care; and Resident #6 who had an abnormal lab level and did not notify the primary care provider resulting in a low lithium level. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. | D 273 | | |

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| D 273 | Continued From page 28<br><br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on February 25, 2021.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 12, 2021. | D 273 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interviews and record reviews, the facility failed to treat the residents with respect, consideration and their right to privacy for 3 of 3 sampled residents (Residents #2, #3, and #4) as evidenced by turning the facility into a non-smoking facility without notice to the residents and failing to allow residents to meet with their Mental Health Providers by choice and in private.<br><br>The findings are:<br><br>1. Telephone interview with the AIC on 02/24/21 at 11:30am revealed:<br>-He stopped residents from smoking in January 2021 because in 2020 there were residents starting fires in their room and cigarette butts everywhere. | D 338 | | |

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-The smoking was causing other problems such as his staff were handing out cigarettes to the residents but would give more to some of the residents than others and that caused problems.
-He met with the residents several times and told the residents if they wanted to smoke then he would find a facility for them that allowed smoking.
-He did not document when he spoke to the residents about making the facility a smoke free facility.

Telephone interview with the facility's primary care provider (PCP) on 02/25/21 at 10:00am revealed he would not have stopped the residents from smoking so suddenly because it would increase their anxiety.

Telephone interview with the Administrator on 02/25/21 at 1:17pm.
-The AIC stopped the smoking in January 2021 because last year there were residents starting fires in their room and throwing their cigarette butts everywhere.
-There were several meetings with the residents where she and the AIC informed them, that if they wanted to smoke, they would help them find a facility that would allow them to smoke.he facility becoming a smoke free facility.
-She did not have documentation of dates and times she spoke to the residents about this facility becoming a smoke free facility.

a. Review of Resident #2's current FL-2 dated 07/11/20 revealed diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), osteoarthritis, seizure disorder, and tobacco abuse.

Interview with Resident #2 on 02/24/21 at

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10:30am revealed:
-The AIC used to let him smoke at certain hours of the day but stopped everyone from smoking all at once.
-The AIC told him, if he did not like what they were doing to "get out".
-His favorite thing to do is smoke and when that got taken away he became anxious.
-That was his right to smoke outside in the designated smoking area.

b. Review of Resident #4's current FL-2 dated 02/11/21 revealed diagnoses included schizophrenia, autistic spectrum disorder, vitamin D deficiency, hyponatremia, tobacco use, and urinary incontinence.

Interview with Resident #4 on 02/24/21 at 9:40am revealed:
-He used to smoke outside at certain time without issues.
-The AIC gave him a 15-day discharge notice because he did not want to quit smoking and the AIC made the facility a "no smoking facility" and Resident #4 wanted to leave.
-The AIC took away all of the smoking and caffeine in the facility in December 2020, without any notice.
-He had been smoking since he was 16, and now he was 32, so he could not just stop smoking.
-He felt it was his right to smoke.
-He was told by the AIC, he could stop cold turkey and use patches or gum but he had to stop.
-It was always the AIC's "way" and no way else.
-He felt "threatened" by the AIC.
-The AIC was very "controlling" and he did not understand how someone had that much power over anyone.

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

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| D 338 | Continued From page 31<br>02/22/21 revealed:<br>-Diagnoses included schizophrenia and depression.<br>-He had a legal guardian.<br><br>Review of Resident #3's Physician Authorization and Care plan dated 04/06/2020 revealed Resident #3 "likes to smoke".<br><br>Interview with Resident #3 on 02/23/21 at 9:48am revealed:<br>-He used to smoke but was "not allowed anymore".<br>-He could not remember when smoking privileges were stopped.<br>-He did not want to quit smoking but the facility "cut off smoking privileges".<br>-He used to smoke outside, with staff supervision, every two hours.<br><br>Telephone interview with Resident #3's guardian on 02/23/21 at 2:49pm revealed:<br>-She was informed by the AIC that Resident #3 had quit smoking.<br>-She was not aware Resident #3 was required to quit smoking because the AIC had made the building smoke-free.<br><br>Interview with Resident #3 on 02/24/21 at 4:15pm revealed:<br>-It was not his choice to quit smoking.<br>-He would smoke if he was allowed.<br>2. Telephone interview with the AIC on 02/24/21 at 12:00pm.<br>-After the Governor's rule in in April or May 2020, he shut down everything because of COVID-19.<br>-The MHPs were "running wild" in the facility.<br>-They were coming in and out the back door and going to the windows without masks and supervision so he stopped that and told them they | D 338 | | |

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would need to do virtual visits.
-He felt he was protecting the residents from COVID-19.
-The MHP did not like that and threatened him with "how much grief they could cause".
-He thought that some of the residents who had their services did not qualify for them based on something he read.
-He thought if the resident was not homeless or had Intellectual and Developmental Disorder (IDD), they did not qualify and some of the residents had those diagnosis.
-He tried to speak with the MHPs about being a part of their meetings and was told he was not allowed.
-The MHPs were not taking input from him or his staff concerning the residents.
-The MHPs were acting like they were the residents "main providers".
-"The MHP told us and the residents what to do".
-He just wanted to sit in on their therapy to let the MHPs "know what's going on" and he believed it was not against the Health Insurance Portability Act (HIPPA) because he needed to know and have an input about the residents because he knew the residents best.
-He wanted to have a say in their care and the MHP was not acting in the best interest of the residents.
-So he got rid of the MHP and "brought in his own".
-In his opinion, he was protecting the residents by making decisions other than that what the doctors said.
-He understood they were doctors but he "knew" his residents "better than doctors" did.

Telephone interview with the Administrator on 02/25/21 at 1:45pm revealed:
-After COVID-19 started, the MHPs brought food

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and snacks for the residents and she did not want that because the MHPs could expose the residents to COVID-19.
-She offered for the MHPs to do virtual visits and the MHPs "refused".
-The MHPs were in the facility having sessions at first, then the window visits and we could not "supervise" the MHPs and make sure there was no contact with the resident in order to protect the residents from COVID-19.
-They did have masks available for the MHPs to use.
-Staff needed to supervise the residents during their sessions to know what was going on, for example their medications.
-Staff would receive orders after their visits but we "knew our residents better" and should have a say.

Telephone interview with the MHP on 02/26/21 at 11:49am.
-The services that were provided by MH were dropped by the AIC.
-Before they were dropped, the face to face sessions were stopped and MHP were told to provide virtual visits.
-Initially there were window visits with the residents but the facility staff informed them there would be no more window visits because of COVID-19.
-They wore face masks and were not offered any other personal protective equipment (PPE) to wear for all the window visits.
-His Medical Director (MD) even met with the AIC to discuss other options but the AIC would not "go for it".
-It was his opinion that a "face to face" session was in the best interest of the resident.
-A face to face session provided "visual cues" like weight gains and tremors that could signify a

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need for a medication or decrease/stop of a medication.
-The residents who were impacted by the lack of face to face sessions, faced isolation and increased anxiety.
-There was a detrimental impact on the residents causing hospitalizations and their symptoms not being treated to the degree they needed.

a. Review of Resident #2's current FL-2 dated 07/11/20 revealed diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), osteoarthritis, seizure disorder, and tobacco abuse.

Interview with Resident #2 on 02/24/21 at 10:45am revealed:
-He had a MHP and received mental health services through a specialized mental health program (SMHP) through them.
-The AIC stopped his MHP from coming into the facility in April 2020, and about 2-3 months ago and he had to talk to them on the phone.
-He had to receive permission from the AIC to talk to his MHP on their phone at the facility.
-The AIC gave them a cell phone to use but he lost the charging cord and the AIC would not charge it for him.
-He felt "trapped" and "scared" because his MHP could not come in to see them or get in contact with them.
-He felt if the MHP could come to the facility, then they could really see how they were being treated.
-He liked his MHP, and felt they were easy to talk to.

Interview with Resident #2's primary care provider (PCP) on 02/25/21 at 9:00am revealed:
-He was made aware the AIC "severed" their ties

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with the MHPs of the facility because the AIC wanted to have their own "in house" MHP.
-He found out in January - February 2021.
-He only managed his medications with the understanding Resident #2 received mental health services through a MHP.

b. Review of Resident #4's current FL-2 dated 02/11/21 revealed diagnoses included schizophrenia, autistic spectrum disorder, vitamin D deficiency, hyponatremia, tobacco use, and urinary incontinence.

Interview with Resident #4 on 02/24/21 at 10:30am revealed:
-The AIC took away his privileges, and one of those were to see his MHP.
-He felt comfortable with his MHP which he received services through their SMHP.
-The MHP used to take them on outings, and socialized with Resident #4.
-He used to go to the community center until the AIC locked down the facility and would not let them see him.
-There was no more socializing and he became depressed.
-He felt "very threatened" by the AIC because the AIC was so "controlling".

c. Review of Resident #3's current FL-2 dated 02/22/21 revealed:
-Diagnoses included schizophrenia and depression.
-He had a legal guardian.

Review of Resident #3's Physician Authorization and Care plan dated 04/06/2020 revealed Resident #3 was receiving mental health services through a specialized mental health program (SMHP).

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| D 338 | Continued From page 36<br><br>Review of Resident #3's Primary Care Provider's (PCP) progress notes dated 10/08/2020, 12/10/2020, and 02/11/2021 revealed Resident #3's judgment was severely impaired secondary to mental illness.<br><br>Review of a typed letter dated 02/08/21 revealed:<br>-The letter was addressed "To Whom It may concern".<br>-The letter stated Resident #3 no longer wished to have SMHP services due to not needing SMHP services.<br>-The letter further revealed "I can live in my house with meals provided to me, people help me with my medication, and I am more independent now and do not need that level of services anymore".<br>-The letter was signed by Resident #3 and the previous Resident Care Coordinator (RCC).<br><br>Interview with Resident #3 on 02/23/21 at 9:48am revealed:<br>-He did not remember getting SMHP services.<br>-He did not remember seeing the SMHP's provider until the provider was mentioned by name.<br>-He could not recall the last time he saw the SMHP's provider.<br><br>Telephone interview with Resident #3's guardian on 02/23/21 at 2:49pm revealed:<br>-The SMHP team notified her within the last two weeks that Resident #3 had signed a letter wanting to discontinue SMHP services.<br>-The letter was a typed letter and was not written by Resident #3.<br>-There should have been a discussion between herself, the SMHP's team and the facility regarding stopping SMHP services for Resident #3. | D 338 | | |

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| D 338 | Continued From page 37<br><br>Interview with Resident #3 on 02/24/21 at 4:15pm revealed<br>-He signed the letter because he "didn't need it anymore" (SMHP services).<br>-He did not remember who asked him to sign the letter.<br><br>Telephone interview with the SMHP's provider on 02/26/21 at 11:49am revealed:<br>-His SMHP's team began working with residents in the facility in December 2019.<br>-Resident #3's mental health medications were complicated and should be monitored by a mental health provider (MHP).<br>-He believed Resident #3 could learn more skills, such as cooking, and could possibly move to a group home or even a supervised apartment.<br>-The Administrator-in-Charge (AIC) was not offering services to Resident #3 that would allow him to learn additional skills.<br>-The SMHP's team received a faxed letter, dated 02/08/21, typed by the facility stating Resident #3 no longer wished to have SMHP services.<br>-The letter was signed by Resident #3, not his guardian.<br>-He notified the facility the guardian had not signed the letter, and a week later he received the same letter back from the facility, still not signed by the guardian.<br><br>Telephone interview with Resident #3's guardian on 02/26/21 at 1:28pm revealed:<br>-She was not asked by the facility to sign the letter discontinuing SMHP services for Resident #3 prior to being informed of the letter by the SMHP team.<br>-She could not recall if she was asked by the facility to sign the letter after the SMHP team notified her of the letter. | D 338 | | |

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| D 338 | Continued From page 38<br>-She would not have signed the letter because she did not like how it was worded.<br>_____<br>The facility failed to treat the residents with respect, consideration and their right to privacy, which resulted in Residents #2, #3, and #4 not allowed to smoke, as they had since they were admitted to the facility, causing increased anxiety, and feelings of being controlled. The facility failed to allow residents to meet with their Mental Health Providers in private, participate in the MHP SMHP services, Residents #2, #3 and #4, and failed to notify the guardian for Resident #3 causing isolation, increased anxiety and the feeling of being trapped and controlled. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.<br>_____<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on February 25, 2021.<br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 12, 2021. | D 338 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures. | D 358 | | |

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

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Resident #6 and Resident #7) related to not administering two blood pressure medications (Resident #6) and not administering a medication used to treat high glucose (Resident #7).

The findings are:

1. Review of Resident #6's current FL-2 dated 02/22/21 revealed diagnoses included cerebral palsy, neurogenic bladder, schizophrenia, bipolar disorder and hypertension.

a. Review of Resident #6's signed physician order dated 02/01/21 revealed:
-Resident #6 was to receive clonidine (medication used to lower blood pressure) 0.1mg as needed for blood pressure greater than 160.
-Resident #6's blood pressure was to be checked twice daily for seven days.

Review of Resident #6's February 2021 electronic Medication Administration Record (eMAR) revealed:
-There was no entry for clonidine 0.1mg as needed for blood pressure greater than 160.
-Resident #6's blood pressure was checked twice a day from 02/02/21 to 02/04/21 and from 02/06/21 to 02/08/21.
-There was no documentation Resident #6's blood pressure was checked on 02/05/21 or documentation to explain why it was not obtained.

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-There were four instances from 02/02/21 to 02/08/21 where Resident #6's blood pressure was greater than 160 and the clonidine should have been administered; 02/06/21 at 9:00am (190/100), 02/06/21 at 8:00pm (186/85), 02/07/21 at 8:00pm (209/126) and 02/08/21 at 8:00pm (173/103).

Observation on 02/26/21 at 10:28am of medications on hand for Resident #6 revealed there was no clonidine 0.1mg as needed available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/26/21 at 10:37am revealed:
-They did not have an order for Resident #6 for clonidine 0.1mg as needed for blood pressure greater than 160.
-The facility was responsible for faxing medication orders to them.

Interview with Resident #6 on 02/23/21 at 9:30am revealed:
-Staff administered his medications.
-He did not know what medications he was prescribed.

Interview with the Resident Care Coordinator (RCC) on 02/26/21 at 1:52pm revealed:
-The RCC was to responsible to fax new medication orders to the pharmacy.
-She was not employeed by the facility at that time.
-The pharmacy entered the medication into the eMAR system.
-The RCC reviewed the order for accuracy before approving.

Interview with the Primary Care Provider (PCP)

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on 02/25/21 at 9:50am revealed:
-He was not aware Resident #6 was not receiving the clonidine as ordered.
-He was not aware of Resident #6's elevated blood pressure readings.
-Clonidine was a medication used to treat high blood pressure.
-Possible outcomes of high blood pressure included strokes and heart attacks.
-The RCC was responsible to ensure resident eMARs were accurate.
-He expected to be notified of medications not being administered as ordered.

Interview with the Administrator on 02/25/21 at 12:51pm revealed:
-When a medication order was received, the RCC was to fax it to the pharmacy.
-After the pharmacy processed the order, the RCC reviewed it for accuracy and approved it or followed up with the PCP and the pharmacy.
-She thought the clonidine order was not on Resident #6's eMAR because the RCC did not fax the order to the pharmacy.
-The RCC was responsible to ensure physician orders were accurate on resident eMARs.
-She expected medications to be given as ordered.

b. Review of Resident #6's physician progress note dated 02/11/21 revealed:
-Amlodipine 5mg (medication used to lower blood pressure) was to be discontinued.
-Amlodipine 10mg daily was to be started.

Review of Resident #6's February 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for amlodipine 5mg and it was documented as administered from 02/01/21

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to 02/08/21 at 8:00am and from 02/09/21 to 02/20/21 at 7:00am.
-There was an entry for amlodipine 10mg and it was documented as administered from 02/12/21 to 02/24/21 at 7:00am.

Observation on 02/26/21 at 10:28am of medications on hand for Resident #6 revealed:
-There was no amlodipine 5mg available for administration.
-There was a cassette containing amlodipine 10mg tablets dispensed on 02/16/21 with 10 tablets remaining of 16 tablets dispensed.

Telephone interview with a representative from the facility's contracted pharmacy on 02/26/21 at 10:37am revealed:
-The pharmacy was notified by the previous Resident Care Coordinator (RCC) on 02/12/20 that medication discontinue orders were not being transferred automatically from the pharmacy software to the facility eMAR software.
-The pharmacy software company and the facility software company were working on a solution.
-The previous RCC informed the pharmacy at that time she would be responsible to remove any discontinued medications from the resident's eMAR.
-Amlodipine 5mg, 16 tablets, was last dispensed to the facility on 02/02/21.
-One amlodipine 5mg tablet was returned to the pharmacy on 02/18/21.

Interview with the Primary Care Provider (PCP) on 02/25/21 at 9:50am revealed:
-He was not aware Resident #6 had received both amlodipine 5mg and amlodipine 10mg daily from 02/12/21 to 02/20/21.
-Resident #6 could have had experienced low blood pressure due to receiving both amlodipine

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5mg and amlodipine 10mg daily.
-He expected to be notified of all medication errors.

Interview with the Administrator on 02/25/21 at 12:51pm revealed:
-The RCC was responsible to ensure physician orders were accurate on resident eMARs.
-She was not aware the previous RCC was discontinuing orders from the resident's eMARs and not the pharmacy.
-The Clinical Care Coordinator (CCC) reviewed and faxed orders to the pharmacy when the previous RCC left.
-She expected medications to be given as ordered.

2. Review of Resident #7's current FL2 dated 02/22/21 revealed:
-Diagnoses included diabetes mellitus type 2, traumatic brain injury, degenerative joint disease, and deep vein thrombosis.
-There was an order for Novolog Flex pen (used to treat diabetes) administer 10 units subcutaneously before meals, hold if blood sugar if less than 100 or if not eating.

Review of Resident #7's December 2020 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Novolog Flexpen, inject 10 units before each meal three times daily at 7:00am, 11:30am, and 4:30pm.
-Resident #7's Novolog was not administered correctly 4 out of 93 opportunities at 7:00am and 4:30pm.
-On 12/07/20 at 7:00am, the fingerstick blood sugar (FSBS) was documented as 92; there was documentation 10 units of Novolog was administered.

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| D 358 | Continued From page 44<br>-On 12/16/20 at 7:00am, the FSBS was documented as 94; there was documentation 10 units of Novolog was administered.<br>-On 12/16/20 at 4:30pm, the FSBS was documented as 97; there was documentation 10 units of Novolog was administered.<br>-On 12/28/20 at 7:00am, the FSBS was documented as 94; there was documentation 10 units of Novolog was administered.<br>-Resident #7's FSBS ranged from 84-272 from 12/01/20-12/31/20.<br><br>Review of Resident #7's February 2021 eMAR revealed:<br>-There was an entry for Novolog Flexpen, inject 10 units before each meals three times daily at 7:00am, 11:30am, and 4:30pm.<br>-Resident #7's Novolog was not administered correctly 6 out of 70 opportunities at 7:00am and 4:30pm.<br>-On 02/05/21 at 11:30am, the FSBS was not documented; there was documentation 10 units of Novolog was administered.<br>-On 02/06/21 at 11:30am, the FSBS was not documented; there was documentation 10 units of Novolog was administered.<br>-On 02/07/21 at 11:30am, the FSBS was not documented; there was documentation 10 units of Novolog was administered.<br>-On 02/08/21 at 7:00am, the FSBS was not documented; there was documentation 10 units of Novolog was administered.<br>-On 02/08/21 at 11:30am, the FSBS was not documented; there was documentation 10 units of Novolog was administered.<br>-On 02/23/21 at 11:30am, the FSBS was documented as 91; there was documentation 10 units of Novolog was administered.<br>-Resident #7's FSBS ranged from 75-296 from 02/01/21-02/24/21. | D 358 | | |

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| D 358 | Continued From page 45<br><br>Observation of Resident #7's medications available for administration on 2/25/21 at 2:52pm revealed there was one Novolog flex pen with a computer-generated pharmacy label attached to the pen with instructions to administer 10 units three times daily before meals with a dispense date of 11/17/20.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/25/21 at 3:20pm revealed:<br>-The pharmacy had an order dated 08/06/20 for Novolog Flexpen, inject 10 units before meals three times daily.<br>-The pharmacy filled a 90-day supply of Resident #7's Novolog insulin on 11/17/20.<br><br>Interview with a medication aide (MA) on 02/24/21 at 1:04pm revealed:<br>-She was aware Resident #7 had an order for Novolog 10 units to be administered before each meals.<br>-She knew the insulin was to be held if the blood sugar was less than 100 or if the resident did not eat.<br>-She checked the blood sugar for Resident #7 before insulin was administered.<br>-She could not remember Resident #7's blood sugar on 02/05/20, 02/06/20, 02/07/20 or 02/23/20, but remembered it being greater than 100.<br>-There was nowhere else she documented FSBS for Resident #7, she only documented on the eMAR.<br><br>Interview with the Resident Care Coordinator (RCC) on 02/25/21 at 4:25pm revealed:<br>-She administered medications to residents.<br>-She knew Resident #7 had an order for Novolog | D 358 | | |

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| D 358 | Continued From page 46<br>10 units to be administered before each meals.<br>-She knew the insulin was to be held if the blood sugar was less than 100 or if the resident did not eat.<br>-She administered Novolog insulin to Resident #7 on 02/23/21 at 11:30am.<br>-She realized she gave the Novolog insulin by accident.<br>-She was supposed to follow medication orders as written by the physician.<br><br>Interview with the primary care provider (PCP) on 02/25/21 at 9:30am revealed:<br>-He ordered Novolog insulin for Resident #7 to treat diabetes.<br>-He included parameters on the order to prevent Resident #7's blood sugar from dropping too low.<br>-He did not know Resident #7 was administered insulin when his blood sugar was less than 100.<br>-If Resident #7 received insulin when his FSBS was less than 100, the resident would be at risk for hypoglycemia (low blood sugar).<br><br>Interview with the Administrator on 02/25/21 at 1:30pm revealed:<br>-She did not know Resident #7 was administered Novolog insulin when his blood sugar was less than 100, or when the blood sugar was not documented.<br>-Resident #7 was not supposed to receive insulin when his blood sugar was less than 100, and insulin was not to be administered if the FSBS was not taken.<br>-She expected the physician's order to be followed as ordered.<br><br>_____<br>The facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner related to clonidine not being administered to the resident when his blood | D 358 | | |

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| D 358 | Continued From page 47<br>pressure was elevated placing the resident at risk for heart attack or stroke (Resident #6); and Novolog insulin, which was administered when it should have been withheld which placed the resident at risk for hypoglycemia (Resident #7). This failure was detrimental to the health, welfare and safety of the residents and constitutes a Type B Violation.<br>_____<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on February 25, 2021 for this violation.<br><br>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 12, 2021. | D 358 | | |
| D 416 | 10A NCAC 13F .1103(a) Legal Representative Or Payee<br><br>10A NCAC 13F .1103 Legal Representative Or Payee<br>(a) In situations where a resident of an adult care home is unable to manage his funds, the administrator shall contact a family member or the county department of social services regarding the need for a legal representative or payee. The administrator and other staff of the home shall not serve as a resident's legal representative, payee, or executor of a will, except as indicated in Paragraph (b) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews the facility failed to contact a family member or notify the County Department of Social Services (DSS) regarding the need for a legal representative or payee for 1 out of 3 sampled residents (Resident #6). | D 416 | | |

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| D 416 | Continued From page 48<br><br>The findings are:<br><br>Review of Resident #6's current FL-2 dated 02/22/21 revealed diagnoses included cerebral palsy, neurogenic bladder, schizophrenia, bipolar disorder and hypertension.<br><br>Review of Resident #6's Resident Register revealed:<br>-He was admitted to the facility on 08/16/18.<br>-No person was named as Resident #6's responsible person, guardian or Power of Attorney (POA).<br>-The Administrator and Administrator-in-Charge (AIC) were listed as Resident #6's "contact person".<br><br>Review of Resident #6's record revealed there was no documentation a legal guardian or POA had been appointed.<br><br>Interview with Resident #6 on 02/23/21 at 9:30am revealed:<br>-The AIC was his guardian.<br>-The AIC handled all of his medical and money concerns.<br>-The AIC had been his guardian for many years, since the year "19 something".<br><br>Telephone interview with the AIC on 02/25/21 at 1:20pm revealed:<br>-He was Resident #6's medical POA.<br>-He was to fax the POA documentation but it was not received prior to exit.<br>-He had been Resident #6's medical POA for many years even before Resident #6 came to the facility in 2018 when Resident #6 lived in his personal home.<br>-He did not notify a family member or DSS to | D 416 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| AUSTIN ADULT CARE | 511 BUMGARNER INDUSTRIAL DRIVE CONOVER, NC 28613 |

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| D 416 | Continued From page 49<br>assist with the medical decisions or payee.<br><br>Telephone interview with the Administrator of 02/25/21 at 1:22pm revealed:<br>-Resident #6 used to live in her home prior to moving Resident #6 to the group home she owned before he was transferred to the facility.<br>-The AIC was the medical POA for Resident #6.<br>-The AIC did not notify the DSS or family to assist with medical decisions or payee. | D 416 | | |
| D 421 | 10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds<br><br>10A NCAC 13F .1104 Accounting For Resident's Personal Funds<br>(c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure a record of each transaction involving the use of residents' personal funds was maintained in the home and was signed by the resident or marked by the resident with two witnesses' signatures at least monthly verifying the accuracy of the disbursements for 4 of 4 sampled residents (Resident #1, #2, #3 and #4).<br><br>The findings are: | D 421 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 421 | Continued From page 50<br><br>1. Review of Resident #1's current FL2 dated 08/12/20 revealed diagnoses included mild intellectual disability and paranoid schizophrenia.<br><br>Review of Resident #1's Resident Register revealed:<br>-Resident #1 was admitted to the facility on 06/07/19.<br>-On page 3 section D (Request for Assistance), there was no signature requesting the management of the facility handle personal funds.<br><br>Review of Resident #1's record revealed there was no Personal Funds Agreement signed by the resident.<br><br>Review of an untitled document for Resident #1 revealed:<br>-Resident #1's name was listed at the top of the document.<br>-There were various dates listed on the document with dates and amounts listed.<br>-On 11/04/20, there was an amount of $66.00 added and subtracted.<br>-On 11/18/20, there was an amount of $200.00 added and subtracted.<br>-On 12/04/20 there was an amount of $66.00 added and subtracted.<br>-On 01/05/21, there was an amount of $94.00 added and subtracted.<br>-There was no documentation indicating which type of funds were accepted and distributed.<br>-There was no signature from the resident indicating the funds were received.<br><br>Refer to interview with the local long-term care ombudsman on 02/24/21 at 4:21pm.<br><br>Refer to interview with the Resident Care | D 421 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 421 | Continued From page 51<br>Coordinator (RCC) on 02/25/21 at 4:25pm.<br><br>Refer to telephone interview with the Administrator In-Charge (AIC) and Administrator on 02/25/21 at 1:30pm.<br><br>2. Review of Resident #2's current FL-2 dated 07/11/20 revealed diagnoses included schizophrenia, chronic obstructive pulmonary disease (COPD), osteoarthritis, seizure disorder, and tobacco abuse.<br><br>Review of Resident #2's record revealed there was no Resident Register.<br><br>Review of Resident #2's record revealed there was no Personal Funds Agreement signed by the resident.<br><br>Review of Resident #2's record revealed the resident had a contracted representative payee.<br><br>Review of Resident #2's Client Statement from the contracted representative payee revealed:<br>-The payee received funds on behalf of the resident monthly.<br>-The payee managed all government received funds and distributed them per the resident's request.<br>-On a monthly basis, the payee sent the personal needs and government stimulus funds to the facility to distribute to the residents.<br>-On 11/03/20, the payee service sent $66.00 for personal funds to the facility.<br>-On 11/07/20, the payee service sent $200.00 for stimulus funds to the facility's bank account.<br>-On 12/03/20, the payee service sent $66.00 for personal needs to the facility.<br>-On 01/03/20, the payee service sent $53.00 to the facility. | D 421 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 421 | Continued From page 52<br><br>Review of an untitled document for Resident #2 revealed:<br>-Resident #2's name was listed at the top of the document.<br>-There were various dates listed on the document with dates and amounts listed.<br>-On 11/04/20, there was an amount of $66.00 added and subtracted.<br>-On 11/18/20, there was an amount of $200.00 added and subtracted.<br>-On 12/04/20 there was an amount of $66.00 added and subtracted.<br>-On 01/05/21, there was an amount of $55.00 added and subtracted.<br>-There was no documentation indicating which type of funds were accepted and distributed.<br>-There was no signature from the resident indicating the funds were received.<br><br>Interview with a representative from the contracted payee service on 02/25/21 at 1:58pm revealed:<br>-The payee service received all funds on behalf of the residents at the facility.<br>-As the payee, they paid all bills including pharmacy bills, distributed cost of care, personal funds and stimulus funds on behalf of the resident.<br>-Personal funds used to be mailed directly to the resident, but there were issues with residents being able to cash their own checks.<br>-The personal needs funds and requested stimulus funds were sent to the facility for staff to distribute.<br><br>Refer to interview with the local long-term care ombudsman on 02/24/21 at 4:21pm.<br><br>Refer to interview with the Resident Care | D 421 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 421 | Continued From page 53<br>Coordinator (RCC) on 02/25/21 at 4:25pm.<br><br>Refer to telephone interview with the Administrator In-Charge (AIC) and Administrator on 02/25/21 at 1:30pm.<br><br>3. Review of Resident #3's FL-2 dated 02/22/21 revealed diagnoses included schizophrenia, depression, hyperlipidemia, and vitamin D deficiency.<br><br>Review of Resident #3's Resident Register revealed:<br>-The resident was admitted on 05/06/19.<br>-The resident had been appointed a legal guardian.<br><br>Review of Resident #3's record revealed there was no Personal Funds Agreement signed by the legal guardian.<br><br>Review of Resident #3's record revealed the resident had a contracted representative payee.<br><br>Review of Resident #3's Client Statement from the contracted representative payee revealed:<br>-The payee received funds on behalf of the resident monthly.<br>-The payee managed all government received funds and distributed them per the residents' request.<br>-On a monthly basis, the payee sent the personal needs and government stimulus funds to the facility to distribute to the residents.<br>-On 11/17/20, the payee service sent $117.87 for stimulus funds to the facility's bank.<br>-On 12/03/20, the payee service sent $66.00 for personal needs to the facility.<br>-On 01/03/21, the payee service sent $66.00 for personal needs to the facility. | D 421 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 421 | Continued From page 54<br>-On 02/03/21, the payee service sent $66.00 for personal funds to the facility.<br><br>Review of an untitled document for Resident #2 revealed:<br>-Resident #3's name was listed at the top of the document.<br>-There were various dates listed on the document with dates and amounts listed.<br>-On 11/18/20, there was an amount of $118.00 added and subtracted.<br>-On 12/04/20 there was an amount of $66.00 added and subtracted.<br>-On 01/05/21, there was an amount of $66.00 added and subtracted.<br>-On 02/09/21, there was an amount of $66.00 added and subtracted.<br>-There was no documentation indicating which type of funds were accepted and distributed.<br>-There was no signature from the resident indicating the funds were received.<br><br>Interview with Resident #3 on 02/23/21 at 9:48am revealed:<br>-The Administrator-in-Charge (AIC) handled his money.<br>-He was not sure how much he received or when he received it.<br>-He did not sign any documents when he received his money.<br><br>Interview with a representative from the contracted payee service on 02/25/21 at 1:58pm revealed:<br>-The payee service received all funds on behalf of the residents at the facility.<br>-As the payee, they paid all bills including pharmacy bills, distributed cost of care, personal funds and stimulus funds on behalf of the resident. | D 421 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 421 | Continued From page 55 | D 421 | | |

-Personal funds used to be mailed directly to the resident, but there were issues with residents being able to cash their own checks.
-The personal needs funds and requested stimulus funds were sent to the facility for staff to distribute.

Refer to interview with the local long-term care ombudsman on 02/24/21 at 4:21pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/25/21 at 4:25pm.

Refer to telephone interview with the Administrator In-Charge (AIC) and Administrator on 02/25/21 at 1:30pm.

4. Review of Resident #4's current FL-2 dated 02/11/21 revealed diagnoses included schizophrenia, autistic spectrum disorder, vitamin D deficiency, hyponatremia, tobacco use, and urinary incontinence.

Review of Resident #4's Resident Register revealed:
-The resident was admitted on 12/09/18.
-On page 3 section D (Request for Assistance), the resident signed requesting the management of the facility handle personal funds.

Review of Resident #4's record revealed the resident had a contracted representative payee.

Review of Resident #4's Client Statement from the contracted representative payee revealed:
-The payee received funds on behalf of the resident monthly.
-The payee managed all government received funds and distributed them per the resident's request.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| D 421 | Continued From page 56<br><br>-On a monthly basis, the payee sent the personal needs funds and government stimulus funds to the facility to distribute to the residents.<br>-On 11/03/20, the payee service sent $66.00 for personal needs to the facility.<br>-On 11/07/20, the payee service sent $200.00 for stimulus funds the facility's bank account.<br>-On 12/03/20, the payee service sent $66.00 for personal needs to the facility.<br>-On 01/03/20, the payee service sent $60.00 for personal needs to the facility.<br>-On 02/03/20, the payee service sent $59.00 for personal needs to the facility.<br><br>Review of an untitled document for Resident #4 revealed:<br>-Resident #4's name was listed at the top of the document.<br>-There were various dates listed on the document with dates and amounts listed.<br>-On 11/04/20, there was an amount of $66.00 added and subtracted.<br>-On 01/05/21, there was an amount of $60.00 added and subtracted.<br>-There was no documentation indicating funds received by the facility on 11/07/20, 12/03/20 and 01/03/20 was distributed to the resident.<br>-There was no documentation indicating which type of funds were accepted and distributed.<br>-There was no signature from the resident indicating the funds were received.<br><br>Interview with a representative from the contracted payee service on 02/25/21 at 1:58pm revealed:<br>-The payee service received all funds on behalf of the residents at the facility.<br>-As the payee, they paid all bills including pharmacy bills, distributed cost of care, personal funds and stimulus funds on behalf of the | D 421 | | |

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| D 421 | Continued From page 57 | D 421 | | |

resident.
-Personal funds used to be mailed directly to the resident, but there were issues with residents being able to cash their own checks.
-The personal needs funds and requested stimulus funds were sent to the facility for staff to distribute.

Refer to Interview with the local long-term care ombudsman on 02/24/21 at 4:21pm.

Refer to interview with the Resident Care Coordinator (RCC) on 02/25/21 at 4:25pm.

Refer to telephone interview with the Administrator In-Charge (AIC) and Administrator on 02/25/21 at 1:30pm.

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Interview with the local long-term care ombudsman on 02/24/21 at 4:21pm revealed:
-She had complaints from residents in the past year regarding funds.
-She spoke to the Administrator-In-Charge about a month before regarding keeping better records of distributing resident funds.
-She also informed that the resident or guardian would also need to sign when funds were distributed.

Interview with the Resident Care Coordinator (RCC) on 02/25/21 at 4:25pm revealed:
-When residents' funds were received from the payee services, she was responsible for distributing to the residents.
-She documented the transactions on the untitled document with the resident's name to show the amount of money that was distributed.
-She did not get the residents to sign the document.

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| D 421 | Continued From page 58<br>-"I did not think they would sign".<br>-She did not know it was required for residents to sign acknowledging funds were received.<br><br>Telephone interview with the Administrator In-Charge (AIC) and Administrator on 02/25/21 at 1:30pm revealed:<br>-The contracted payee service managed the resident funds.<br>-The personal funds and requested stimulus funds were received from the payee service and distributed by the RCC.<br>-The funds were originally sent to residents from the payee; however some of the residents did not have an identification card and had a hard time cashing their checks.<br>-They thought it was a receipt book located in the office that kept an accurate record of each resident's funds.<br>-The RCC would be responsible for making sure residents signed indicating funds were received.<br>-They did not know the residents signatures were not obtained when funds were distributed. | D 421 | | |
| D 451 | 10A NCAC 13F .1212(a) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting of Accidents and Incidents<br>(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the | D 451 | | |

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| D 451 | Continued From page 59<br>facility failed to report to the local County Department of Social Services for 1 of 3 sampled residents (Resident #7), who required for emergency medical attention.<br><br>The findings are:<br><br>Review of the facility's emergency and accident policy revealed:<br>-An emergency is any situation, which arises suddenly and calls for prompt action.<br>-An accident is an unexpected, unplanned event which may or may not cause injury.<br>-If it appears that the resident may be injured, completely fill out accident/incident or death report and notify the local Department of Social Services (DSS) as appropriate.<br><br>Review of Resident #7's current FL2 dated 02/22/21 revealed diagnoses included diabetes mellitus type 2, traumatic brain injury, degenerative joint disease, and deep vein thrombosis.<br><br>Review of Resident #7's Emergency Department (ED) Report dated 02/11/21 revealed:<br>-Resident #7's chief complaint was musculoskeletal due to fall.<br>-The resident had a 3 centimeter (cm) laceration to his left forearm.<br>-The resident had an x-ray of his forearm and there was diffuse soft tissue swelling and widening of his joint space.<br><br>Review of Resident #7's incident/accident reports revealed there was no incident report documenting Resident #7 had a fall.<br><br>Telephone interview with another medication aide (MA) on 02/25/21 at 8:10pm revealed: | D 451 | | |

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| D 451 | Continued From page 60<br>-She worked 02/11/21 in the evening when Resident #7 fell.<br>-She and the personal care aide (PCA) completed the incident report and placed it on the previous Resident Care Coordinator's (RCC) desk.<br>-She did not know where the incident report when went after she gave it to the RCC.<br>-She was not responsible for sending the incident report anyone else.<br><br>Interview with the RCC on 02/24/21 at 12:00pm revealed:<br>-When a resident went to the ED an incident report was to be completed and faxed to the local DSS within 24 hours.<br>-She did not know if the report had been faxed to the local DSS, as she did not begin working until 02/19/21.<br><br>Telephone interview with the Adult Home Specialist (AHS) on 02/24/21 at 4:13pm revealed:<br>-She had not received any accident/incident reports regarding Resident #7's fall.<br>-She was not notified by phone or in writing of Resident #7's fall that occurred on 02/11/21.<br><br>Telephone Interview with the Administrator on 02/25/21 at 1:30pm revealed:<br>-She did not know an incident report was not faxed to the local DSS.<br>-The staff who observed the incident were responsible for completing the incident report.<br>-The RCC was responsible for sending the incident report to the local DSS within 24 hours.<br>-She and the Administration In-Charge (AIC) took full responsibility for overseeing the RCC's duties were fulfilled. | D 451 | | |

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| D 612 | Continued From page 61 | D 612 | | |
| D 612 | 10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)<br><br>10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM<br>(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious<br>disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and<br>published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease<br>outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health<br>department, the specific guidance or directives shall be implemented by the facility.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure implementation of the facility 's infection control policy, and guidance issued by the Centers for Disease Control and Prevention (CDC) for screening all visitors and staff entering the facility by taking their temperature and asking the COVID-19 screening questions recommended by the CDC.<br><br>The finding are:<br><br>Review of the Centers for Medicare & Medicaid Services (CMS) and the CDC guidance dated 04/20/20 revealed:<br>-Long-term care facilities should immediately implement symptom screening for all.<br>-Every individual regardless of reason entering a long-term care facility (including residents, staff, visitors, outside healthcare workers, vendors, | D 612 | | |

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| D 612 | Continued From page 62<br>etc.) should be asked about COVID-19 symptoms and they must also have their temperature checked<br>-In accordance with previous CDC guidance, every resident should be assessed for symptoms and have their temperature checked every day.<br><br>Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 12/14/20 revealed:<br>- Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed COVID-19 infection and that they are practicing source control.<br>-Screen and triage everyone entering a healthcare facility for signs and symptoms of COVID-19 prior to entering the facility.<br>-Screening questions included: Have you experienced any of the following symptoms in the past 48 hours: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea.<br>- Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes)<br>with: Anyone who is known to have laboratory-confirmed COVID-19? OR Anyone who has any symptoms consistent<br>with COVID-19?<br>-Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?<br>- Are you currently waiting on the results of a COVID-19 test? | D 612 | | |

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| D 612 | Continued From page 63<br><br>Review of the facility's policy on Infection Prevention and Control Manual revealed:<br>-Ongoing, frequent monitoring for potential symptoms of respiratory infection as needed throughout the day for signs and symptoms for both residents and staff.<br>-The facility will actively screen for international travel within the last 14 days, signs and symptoms of respiratory infection such as fever, cough, shortness of breath or sore throat, and in the past 14 days has the individual come in contact with someone with a confirmed case of COVID-19.<br><br>Review of the facility's COVID-19 screening log for associates, health care providers and residents revealed:<br>-There was an entry for the staff/resident or visitors name, date, time in, time out, and initials of the person doing screening.<br>-There was no list of COVID-19 signs and symptoms and risks of exposure or screening questions for staff, residents or visitors.<br>-There was no space to indicate response to the COVID-19 signs and symptoms and possible risk to exposure.<br>-There was no space for temperature.<br><br>Review of the facility's staff/visitor COVID-19 screening logs for 01/01/21 to 02/24/21 revealed:<br>-There was no list of COVID-19 signs and symptoms and risks of exposure or screening questions for staff, residents or visitors.<br>-There was no space to indicate response to the COVID-19 signs and symptoms and possible risk to exposure.<br>-There was no space to indicate response of the temperatures. | D 612 | | |

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| D 612 | Continued From page 64<br><br>Review of the facility's resident COVID-19 screening logs 01/01/21 to 02/24/21 revealed:<br>-There was no list of COVID-19 signs and symptoms and risks of exposure or screening questions for staff, residents or visitors.<br>-There was no space to indicate response to the COVID-19 signs and symptoms and possible risk to exposure.<br>-There was no space to indicate the response of the temperatures.<br><br>Interview with the Resident Care Coordinator (RCC) on 02/23/21 at 12:36pm revealed:<br>-All staff and visitors were to be screened by taking their temperatures and completing the facility's screening form, prior to entering the facility.<br>-All residents were to be screened by taken their temperatures and completing the facility's screening form three times a day.<br>-There were no COVID-19 questions on the form.<br>-She was responsible for reviewing the screening forms for completion monthly.<br>-She had not had a chance to review the screening forms because she was hired 3 days ago.<br>-There were COVID-19 questions that should have been asked to all visitors, staff and residents according to their facility policy.<br><br>Telephone interview with the Administrator on 02/25/21 at 2:15pm revealed:<br>-Residents received temperature checks three times a day and as needed and COVID-19 screening questions were to be asked and the screening form was to be filled out.<br>-Staff and visitors were screened for COVID-19 signs and symptoms and temperatures were taken and the screening form was to be filled out before entrance to the facility. | D 612 | | |

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| D 612 | Continued From page 65<br><br>-There was no area on the screening form for the COVID-19 screening questions to be entered.<br>-The Administrator-in-Charge (AIC) was "ultimately" responsible to make sure the screening forms were completed on every visitor, staff and resident on a daily basis.<br>-She did not know the screening forms were not filled out with the temperatures or documentation of the screening questions.<br><br>Telephone interview with the AIC on 02/26/21 at 3:20pm revealed:<br>-The policy was to ask the COVID-19 questions, take temperatures and document them on the form for all residents, staff and visitors.<br>-He was not aware there was no place to document the answer to the questions and temperature results.<br>-He would speak to the RCC on a daily basis to make sure the forms were completed on all staff, residents and visitors. | D 612 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' 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 interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to healthcare, discharge of residents, resident rights and medication administration. | D912 | | |

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| D912 | Continued From page 66<br><br>The findings are:<br><br>1. Based on interviews and record reviews, the facility failed to provide a safe and orderly discharge for 4 of 4 sampled resident (Residents #1,#2, #4, and #5) as evidence by failing to coordinate an appropriate and safe discharge for the resident, who was discharged to a local hotel where no one was able to meet the needs of the resident (#2), a resident displaying suicidal behaviors (#5), a resident who left the facility without transportation to the new placement (#4), and to provide notification or consultation of the discharge to the mental health provider while services were being provided for the resident (#1). [Refer to Tag 0230, 10A NCAC 13F .0702(f) Discharge of Residents (Type A2 Violation)].<br><br>2. Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up with the provider for 3 of 4 sampled residents (Resident #7, #2, and #6 ) related to not providing notification regarding a fall (#7), aggressive behaviors (#2), and having a lab drawn in a timely manner and notifying the physician of the lab results (#6). [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].<br><br>3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Resident #6 and Resident #7) related to not administering two blood pressure medications (Resident #6) and not administering a medication used to treat high glucose (Resident #7). [Refer to Tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. | D912 | | |

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| D912 | Continued From page 67<br><br>4. Based on interviews and record reviews, the facility failed to treat the residents with respect, consideration and their right to privacy for 3 of 3 sampled residents (Residents #2, #3, and #4) as evidenced by turning the facility into a non-smoking facility without notice to the residents and failing to allow residents to meet with their Mental Health Providers by choice and in private. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. | D912 | | |