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	HAL096024	A. BUILDING: _____ B. WING _____	04/16/2021

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D 000	Initial Comments The Adult Care Licensure Section and the Wayne County Department of Social Services conducted an annual survey and complaint investigation on 04/12/21 - 04/16/21.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the environment was clean and free of hazards related to live and dead bed bugs in residents' rooms. The findings are: Observations in resident room #19 on 04/14/21 at 9:50am revealed: -There was one large, dead bed bug with a dried, red colored matter surrounding the bed bug on the floor bed side the resident's bed. -There was one dried circular shaped red colored stain located at the head of the resident's bed on the resident's bed spread. Review of the pest control provider service slips/invoices for the facility revealed: -On 01/20/21, the pest control provider completed a bed bug treatment for 10 resident rooms.	D 079		

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-On 02/17/21, the pest control provider completed a bed bug treatment for 11 resident rooms.
-On 03/17/21, the pest control provider completed a bed bug treatment for 10 resident rooms.
-On 04/07/21, the pest control provider treated room 2 and 6 for bed bugs, found live bedbugs in both rooms. Also, the pest care provider placed one ready-to-use bait box and one glue trap in the main office for mice near the window.

Interview with a resident in room #19 on 04/14/21 at 9:50am revealed:
-There were times bed bugs would bite him at night.
-He was able to feel bed bugs crawling and biting him.
-He had noticed blood spots on his bed linens at times.
-He last saw a bed bug last night (04/13/21).
-When he saw a bed bug, he "smashed the blood" out of them with his fingers.
-Whenever he saw a bed bug, it was usually late at night and he would yell for staff.
-Sometimes when he saw bed bugs he yelled "hey, hey" to get the staffs' attention but at times there were no staff around.
-Staff were aware bed bugs were in his room because he had told them but was unsure when.
-When he found bed bugs they were usually around his neck and on his stomach.
-He had noticed bed bugs in his room for approximately one month.

A second interview with the resident in room #19 on 04/14/21 at 9:57am revealed:
-He thought it was a few weeks ago when he saw someone spraying in his room.
-He thought the person spraying was spraying for bed bugs but was not sure.
-When the resident's room was treated for bed

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bugs, his personal belongings were not removed from his room but thought his bed sheets were removed and replaced on his bed.
-A few days ago, he told a staff that bed bugs were biting him at night when the staff was assisting him in the shower but was not sure what the staff's name was.

Interview with a medication aide (MA) on 04/15/21 at 3:34pm revealed staff were responsible to notify the Administrator if any bed bug activity seen or reported by residents

Interview with the Administrator on 04/15/21 at 10:10 am revealed:
-She was not aware of any bed bug activity in resident room #19.
-She was not aware the resident in resident room #19 had been bitten or felt bed bugs crawling on him at night.

Interview with a housekeeper on 04/15/21 at 10:00am revealed:
-The facility's contracted pest control provider was here last week spraying in the hallways of the facility.
-He had not seen any insects or pests except for a few roaches.
-He had not received any training by anyone at the facility regarding how to look for bed bugs or what a bed bug looked like.
-He had to move beds "to the side" when the facility's contracted pest control provider sprayed for insects in the residents' rooms.
-He mainly cleaned in common areas and other housekeepers cleaned in the residents' rooms.

Observation of resident room #5 on 04/15/21 at 2:35pm revealed:
-There was one dead bed bug adhered to the wall

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on the right side of the resident's bed.
-There were scattered small black areas of matter on the mattress at the head of the bed on the left side with one dead bed bug adhered to the mattress material.
-There were small, black areas of matter scattered across the wooden headboard of the resident's bed.

Interview with one of the residents assigned to room #5 on 04/15/21 at 2:35pm revealed:
-She saw a red colored bug crawling on her hand a few nights ago but did not know what it was.
-She did not have any skin marks and had not been bitten by bed bugs that she knew of.

Interview with the Administrator on 04/15/21 at 12:14pm revealed:
-The facility's pest control provider was "just here" at the facility last week.
-The facility's pest control provider came to the facility on a scheduled and as needed basis.
-One time per month, the facility's pest control provider treated 1-11 rooms then the following month rooms 12-23 and or anywhere else in between if needed.
-There were some months the provider does the "normal pest control treatment" for pest prevention in general.
-She was not aware of any issues or concerns with bed bugs in resident room #19.
-Staff were expected to report any issues or concerns residents had with bed bugs immediately.
-The facility had a process when bed bugs were seen which included removing the linens from the residents' bed and placing the removed linens in a tied bag, staff then transported the linens off site to a laundromat and staff were responsible to place the linens in the dryer then wash the linen

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and dry the linens.
-When the facility's contracted provider treated the room for bed bugs the resident assigned to the room had remain out of the room for a few hours.
-The residents' clothes were not removed from the room unless bed bug activity was seen in or around the residents' clothing.
-The facility's pest control provider treated 10 rooms in the facility on 03/24/21.

Confidential telephone interview with a staff revealed:
-The bed bugs were an issue at the facility.
-She had observed the resident assigned to room 19 sitting in his wheelchair all night because the bed bugs were biting him.
-The resident asked the staff for help because he was being bitten by the bed bugs.
-The staff assisted the resident to bathe, change his clothes and provided the resident with new bed linens.
-The staff applied Vaseline to the resident's skin to soothe the areas where the resident was bitten.
-She was not aware of any order for any type of topical creams ordered for the resident.
-She saw blood spots on the resident and the bed linens where bed bugs had bitten the resident.
-The Administrator was notified about the incident.
-The staff was concerned that the Administrator did not notify the facility's contracted pest control provider and contacted people she knew personally to spray the facility for the bed bugs.
-The last time she saw bed bugs was around 03/07/21.

Observation at the front of the facility on 04/16/21 at 12:42pm revealed the facility's contracted pest

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control provider arrived at the facility.

Observations made in resident room #6 on 04/16/21 at 9:50am revealed:
-The resident was in bed resting quietly with her eyes closed and covered with a blanket.
-There was a live red colored bed bug crawling on the bed covers.
-The resident denied having any bedbug bites.

Interview with a resident in room #9 on 04/16/21 at 10:10am revealed:
-About 2 months ago, he was bit repeatedly on his legs and arms by bed bugs.
-The bedbugs were "bad" in this room, but the room was sprayed by staff and he had not seen any bedbugs recently.
-There was still evidence of bed bug activity on the left wall beside his bed.

Observation in resident room #9 on 04/16/21 at 10:30am revealed:
-There was a large amount of bedbug excretion on the left wall on and around a metal rod at the resident's bed which was against the wall.
-There was no evidence of live bug beds in the room.

Interview with the facility's contracted pest control provider on 04/14/21 at 3:02 pm revealed:
-He treated the facility for bedbugs and cockroaches on 03/17/21.
-10 bedrooms were sprayed for bedbugs during that visit.
-Facility staff reported seeing live bedbugs in room number 1.
-Bedroom number 1 was "sprayed" for bedbugs.
-He did not see any bedbugs in room number 1.
-He sprayed 10 rooms each visit to the facility.
-He had 2 technicians that sprayed the facility

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D 079	Continued From page 6 when he is unable to go himself. Interview with the Administrator on 04/16/21 at 1:39pm revealed: -There had been issues with bed bugs at the facility however a pest control provider treated the facility for them. -The staff would have been responsible to contact the residents' PCP If a resident was bitten by bed bugs and had complaints of skin irritation. -The PCP's had ordered a certain cream to treat for bed bug bites, however, she was not sure if an order had been given for any of the residents. -The RCC would know if any topical creams had been ordered to treat bed bug bites. -She was not aware of any issues with residents being bitten by bed bugs.	D 079		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 6 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of documents from Staff A's personnel record reveled: -Staff A was hired on 07/24/19. -There was no documentation of a statewide	D 139		

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D 139	Continued From page 7 criminal background check being completed. Attempted interview with Staff A on 04/16/21 was unsuccessful. Interview with the Administrator on 04/16/21 at 5:10pm revealed: -It was her responsibility to complete a criminal background check prior to Staff A's start date. -She was not sure why it was not completed prior to hire.	D 139		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision according to needs for 3 of 9 sampled residents (#4, #13, #16) including failure to monitor residents that were at an increased risk for elopement (#4, #13, #16). The findings are: Review of the facility's sign out policy dated 03/22/18 revealed: -Residents were required to sign out on the sign out sheet prior to exiting the grounds of the facility. -If a resident left the building without signing out	D 270		

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and this was witnessed by a staff, the staff was required to sign on the sign out sheet that the resident left the building and sign their signature with the date and time.

Review of the facility's Elopement Policy dated 03/22/18 revealed:
-When a resident signed out and has not returned within time frame of his/her normal departure/return then this resident will be considered for elopement.
-The procedure that the facility has in place for a missing person will then be followed.

Review of the facility's undated "Steps to Follow for Missing Residents" document revealed:
-The first step was to search the facility, bedrooms, closets and bathrooms.
-The second step was to call 911 and notify that there was a possible wanderer who may be lost.
-The third step was to do an immediate perimeter search, looking at walkways, sides of buildings, in the road way, and yards that are immediately adjacent to grounds of facility.
-The fourth step was to complete the check list for the missing person which included: name, age, sex, race, last known location and time see, clothing worn, shoes worn, last time seen, personal habits such as smoker or particular behaviors, medical history that may affect person's safety, mental status, location of family members and previous address and similar past experiences with resident.
-The fifth step was to call the family or the responsible person.
-The sixth step was to call Local County Department of Social Services when possible.
-The seventh step was to not disturb the missing person's room or personal articles and provide a photo and scent article to authorities.

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-The final step was to complete an incident/accident report within 24 hours to the Department of Social Services.

1.Review of Resident #16's current FL-2 dated 04/15/21 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, obesity, mild mental retardation, schizophrenia paranoid, hyperprolactinemia, hyperlipidemia, pituitary adenoma, and coronary artery disease.
-His orientation level was blank.
-Inappropriate behavior included injurious to others.
-He required personal assistance with bathing and dressing.

Review of Resident #16's current plan of care dated 04/15/21 revealed:
-He was physically abusive and injurious to others.
-He was currently receiving medications for mental health behavior.
-He required supervision with eating.
-His assistance level with toileting, transferring, and ambulation/locomotion were blank.
-He required limited assistance with dressing and grooming/personal hygiene.
-He required extensive assistance with bathing.

Review of a local law enforcement incident/investigation report dated 12/25/20 revealed:
-The date/time reported was on 12/25/20 at 9:57pm.
-Local law enforcement responded to a call from the local gas station in reference to a possible breaking and entering call.
-Upon arriving to the local gas station, the store clerk advised a male had entered the store

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through the door that was out of service and told her he would kill her if she did not let him behind the counter.
-The male then went behind the counter and stole some cigarettes, rolling paper, and an alcoholic beverage before leaving the store on foot.
-Local law enforcement left the local gas station and located the suspect on the corner.
-The male held his arms up and was wearing shorts, a sweater, and a hat.
-The male did not have any of the stolen products on him.
-The male was asked to sit inside the patrol vehicle because it was freezing outside, and he was wearing shorts.
-The male appeared to have tears in his eyes.
-He stepped back to the local law enforcement's vehicle and local law enforcement opened the car door for him.
-The male tried to open the car door even though it was already opened.
-Local law enforcement advised him it was open, and he could sit down.
-He got into the front passenger seat without incident.
-He was asked where he was from and he could not tell local law enforcement.
-He was able to state his name.
-He stated a middle name, but the local law enforcement officer could not understand him.
-When he was asked to spell his middle name, he began speaking incoherently again.
-He was asked for his date of birth and he kept saying his name.
-Another male walked by the patrol care vehicle using profanity advising the male tried to rob him by trying to take his bag.
-It was determined the man was in an altered state of mind and had left the facility.
-Local law enforcement contacted the facility and

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spoke with a staff member.
-A staff member was asked if she was missing Resident #16 and she said they should not be missing him.
-A description of the male was given to a staff member and she confirmed it was Resident #16.
-Emergency Medical Services (EMS) was called to check him out.
-When EMS arrived, local law enforcement was approached by another male who advised Resident #16 walked up to his vehicle and told him he was going to steal his truck.
-The male advised Resident #16 he would shoot him if he did not get off him and back down.
-The male advised during his altercation with Resident #16 the cigarettes and stolen items fell out of Resident #16's pocket.
-He advised Resident #16 picked all the items up except a pack of rolling papers and walked away without further incident.
-Resident #16 was transported to the hospital and the facility was notified.
-Adult Protective Services was also notified.

Review of the facility's round sheet dated 12/25/20 revealed:
-There were columns with the residents' names listed and columns for staff initials.
-The rounding times for first shift were documented as 7:00am, 9:00am, 11:00am, 1:00pm, and 3:00pm.
-The rounding times for second shift were documented as 5:00pm, 7:00pm, 9:00pm, and 11:00pm.
-The rounding times for third shift were documented as 1:00am, 3:00am, and 5:00am.
-Resident #16 was documented as present on 12/25/20 during second shift.
-Resident #16 was documented as present on 12/25/20 during third shift.

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Telephone interview with a local law enforcement officer on 04/15/21 at 2:42pm revealed:
-He was the officer who responded to a call related to possible breaking and entering on 12/25/20.
-Local law enforcement responded to a call from the local gas station in reference to a possible breaking and entering call.
-Resident #16 had entered the store and robbed the local gas station of cigarettes, rolling papers, and an alcoholic beverage.
-Resident #16 had threatened to kill the store clerk for these items.
-Resident #16 left on foot after the items were given to him.
-After Resident #16 left the local gas station it was reported to local law enforcement, he had tried to rob another male for his bag and tried to carjack another male's truck.

Interview with the Resident Care Coordinator (RCC) on 04/16/21 at 4:33pm revealed:
-Resident #16 had been "better" and had not tried to leave the facility for "awhile."
-Residents #16 was deemed to not be safe to walk to the store by himself.
-Resident #16's current supervision in place was staff monitoring every 2 hours.

Interview with the Administrator on 04/16/21 at 5:13pm revealed:
-Residents #16 was deemed to not be safe to walk to the store by himself.
-Supervision interventions in place were staff rounding every two hours.
-Interventions in place after his elopement dated 12/25/20 were medication adjustments by his mental provider.
-The interventions were effective and Resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 #16 had not tried to leave the facility. Based on observations, interviews and record reviews it was determined that Resident #16 was not interviewable. Attempted telephone interviews with Resident #16's primary care provider on 04/16/21 at 10:00am and 10:46am were unsuccessful. Attempted telephone interview with Resident #16's mental health provider on 04/16/21 at 10:05am was unsuccessful. Refer to the interview with the Secretary on 04/14/21 at 9:53am. Refer to the telephone interview with a local law enforcement officer on 04/15/21 at 11:15am. Refer to the interview with a housekeeper on 04/15/21 at 11:56. Refer to the interview with a medication aide (MA) on 04/15/21 at 12:09pm. Refer to the interview with the Administrator on 04/15/21 at 12:13pm. Refer to the interview with the RCC on 04/16/21 at 4:33pm. 2. Review of Resident #13's current FL-2 dated 07/22/20 revealed: -Diagnoses included status post coronary artery stent, coronary artery disease in native artery, schizophrenia, chronic obstructive pulmonary disease, and Hepatitis C. -His orientation level was blank. -His neurological and respiratory sections were	D 270		

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blank.
-His inappropriate behavior was documented as a wanderer.
-He required personal care assistance with bathing and dressing.
-He was semi-ambulatory.
-His functional limitation was speech.
-He was incontinent at times of bladder and bowel.

a. Review of a local law enforcement incident/investigation report dated 12/29/20 revealed:
-The date/time reported was on 12/29/20 at 2:52am.
-The last known secure was 12/29/20 at 1:02am.
-Local law enforcement observed what appeared to be an elderly person walking in the area.
-It was very cold outside, so local law enforcement went to check on the person to make sure they were ok.
-Local law enforcement pulled up alongside the man who was walking, and he later identified himself as Resident #13 when asked where he was walking to.
-Resident #13 asked where he was, and local law enforcement told him where he was.
-As local law enforcement was speaking with Resident #13, he received a call from the facility in reference to Resident #13 missing from the facility.
-Local law enforcement informed the facility staff member he had located Resident #13 and would bring back Resident #13 to the facility.

Review of the facility's round sheet dated 12/29/20 revealed:
-There were columns with the residents' names listed and columns for staff initials.
-The rounding times for first shift were

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documented as 7:00am, 9:00am, 11:00am, 1:00pm, and 3:00pm.
-The rounding times for second shift were documented as 5:00pm, 7:00pm, 9:00pm, and 11:00pm.
-The rounding times for third shift were documented as 1:00am, 3:00am, and 5:00am.
-Resident #13 was documented as present on 12/29/20 during third shift.

Interview with the Administrator on 04/15/21 at 12:13pm revealed:
-Resident #13 was an elopement risk but was not on increased supervision checks.
-Resident #13 "loved" to go to the front door of the facility.
-She initiated increased supervision checks every 30 minutes for Resident #13 on 04/15/21.

Telephone interview with a local law enforcement officer on 04/15/21 at 3:15pm revealed:
-He was the officer who was working the night shift on 12/29/20.
-Local law enforcement observed what appeared to be an elderly person walking in the area.
-It was very cold outside, and he was wearing inappropriate clothing, so local law enforcement went to check on the person to make sure they were ok.
-Local law enforcement pulled up alongside the man who was walking, and he later identified himself as Resident #13 when asked where he was walking to.
-Resident #13 asked where he was, and local law enforcement told him where he was.
-As local law enforcement was speaking with Resident #13, he received a call from the facility in reference to Resident #13 missing from the facility.
-When he spoke with the facility staff to let them

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know he had Resident #13 in the police car, the facility staff member estimated Resident #13 could have left the facility possibly 2 hours ago, but they were not sure.

Interview with a Medication Aide on 04/15/21 at 3:49pm revealed:
-Resident #13 was at risk for elopement from the facility.
-Resident #13 "every now and then" would just leave the facility and would tell staff he was going home.
-Staff never knew when Resident #13 would follow through with leaving when they would see him at the front door of the facility.
-Resident #13's current supervision intervention in place was every 2 hours staff rounds.
-She was not aware of any other supervision interventions in place to present for Resident #13.
-"We" tried to keep close supervision of Resident #13.
-Resident #13 was always by staff.
-For example, during meal times, while meals were being served by staff to residents, Resident #13 would remain in the facility's dining room even if he was finished with his meal.

Interview with the Resident Care Coordinator (RCC) on 04/16/21 at 4:33pm revealed:
-Resident #13 was at risk for elopement from the facility.
-Residents #13 was deemed to not be safe to walk to the store by himself.
-Resident #13's current supervision in place was staff monitoring every 30 minutes, but she could not recall when this was initiated by the facility.

Interview with the Administrator on 04/16/21 at 5:13pm revealed:
-Resident #13 was identified as an elopement

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risk.
-Resident #13 was deemed to not be safe to walk to the store by himself his confusion and his mental health history.
-Supervision interventions in place were staff rounding every two hours.
-His supervision staff rounds were increased to every 30 minutes on 04/15/21.

Based on observations, interviews and record reviews it was determined that Resident #13 was not interviewable.

Attempted telephone interviews with Resident #13's primary care provider on 04/16/21 at 10:00am and 10:46am were unsuccessful.

Attempted telephone interview with Resident #13's mental health provider on 04/16/21 at 10:05am was unsuccessful.

Refer to the interview with the Secretary on 04/14/21 at 9:53am.

Refer to the telephone interview with a local law enforcement officer on 04/15/21 at 11:15am.

Refer to the interview with a housekeeper on 04/15/21 at 11:56.

Refer to the interview with a medication aide (MA) on 04/15/21 at 12:09pm.

Refer to the interview with the Administrator on 04/15/21 at 12:13pm.

Refer to the interview with a second medication aide on 04/15/21 at 3:49pm.

Refer to the interview with the RCC on 04/16/21

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D 270	Continued From page 18 at 4:33pm. b. Review of a local law enforcement incident/investigation report dated 03/14/21 revealed: -The date/time reported was on 03/14/21 at 10:00pm. -Local law enforcement responded to the facility in reference to a missing person. -Local law enforcement arrived at the facility and spoke with staff members who were looking for Resident #13. -Resident #13 had walked off from the facility. -Local law enforcement patrolled the area to attempting and to locate Resident #13. -Local law enforcement returned to their office and spoke with a staff member by telephone who provided more information on Resident #13. -While gathering the information for the be on the look-out or BOLO report, a "suspicious person call came out of the area." -The clothing description of the suspicious person matched that of what Resident #13 had on when he left the facility. -Local law enforcement confirmed it was Resident #13 and he was transported back to the facility. Review of the facility's round sheet dated 03/14/21 revealed: -There were columns with the residents' names listed and columns for staff initials. -The rounding times for first shift were documented as 7:00am, 9:00am, 11:00am, 1:00pm, and 3:00pm. -The rounding times for second shift were documented as 5:00pm, 7:00pm, 9:00pm, and 11:00pm. -The rounding times for third shift were documented as 1:00am, 3:00am, and 5:00am.	D 270		

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D 270	Continued From page 19 -Resident #13 was documented as present on 03/14/21 during second shift. Telephone interview with a local law enforcement officer on 04/15/21 at 11:15am revealed: -He was the officer who responded to the missing person report for Resident #13 on 03/14/21. -He was unable to locate Resident #13 in the area surrounding the facility. -He returned to their office and spoke with a staff member by telephone who provided more information on Resident #13. -While gathering the information for the be on the look-out or BOLO report, a "suspicious person call came out of the area." -The clothing description of the suspicious person matched that of what Resident #13 had on when he left the facility. -Resident #13 had managed to leave the facility and travel about approximately 12-15 miles from the facility to a surrounding town. -Resident #13 was observed to walking past the town's fire department and 911 was notified. -When in a surrounding town's local law enforcement arrived on scene and identified Resident #13 was under the influence of alcohol. -Resident #13's provided his name, his identity was confirmed into the local law enforcement's database, and it was determined he had outstanding warrants in the county. -Local law enforcement from the surrounding town confirmed it was Resident #13 and he was transported back to the facility. Interview with the Administrator on 04/15/21 at 12:13pm revealed: -Resident #13 was an elopement risks but was not on increased supervision checks. -Resident #13 "loved" to go to the front door of the facility.	D 270		

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-She initiated increased supervision checks every 30 minutes for Resident #13 on 04/15/21.

Interview with a medication aide on 04/15/21 at 3:49pm revealed:
-Resident #13 was at risk for elopement from the facility.
-Resident #13 "every now and then" would just leave the facility and would tell staff he was going home.
-Staff never knew when Resident #13 would follow through with leaving when they would see him at the front door of the facility.
-Resident #13's current supervision intervention in place was every 2 hours staff rounds.
-She was not aware of any other supervision interventions in place to present for Resident #13.
-"We" tried to keep close supervision of Resident #13.
-Resident #13 was always by staff.
-For example, during meal times, while meals were being served by staff to residents, Resident #13 would remain in the facility's dining room even if he was finished with his meal.
-She was the facility supervisor who was working and made a missing person report for Resident #13 on 03/14/21.
-She could not recall where and what happened related to Resident #13's elopement on 03/14/21.

Interview with the Resident Care Coordinator (RCC) at 4:33pm revealed:
-Resident #13 was at risk for elopement from the facility.
-Residents #13 was deemed to not be safe to walk to the store by himself.
-Resident #13's current supervision in place was staff monitoring every 30 minutes, but she could not recall when this was initiated by the facility.

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Interview with the Administrator on 04/16/21 at 5:13pm revealed:
-Resident #13 was identified as an elopement risk.
-Residents #13 was deemed to not be safe to walk to the store by himself his confusion and his mental health history.
-Supervision interventions in place were staff rounding every two hours.
-His supervision staff rounds were increased to every 30 minutes on 04/15/21.

Based on observations, interviews and record reviews it was determined that Resident #13 was not interviewable.

Attempted telephone interviews with Resident #13's primary care provider on 04/16/21 at 10:00am and 10:46am were unsuccessful.

Attempted telephone interview with Resident #13's mental health provider on 04/16/21 at 10:05am was unsuccessful.

Refer to the interview with the Secretary on 04/14/21 at 9:53am.

Refer to the telephone interview with a local law enforcement officer on 04/15/21 at 11:15am.

Refer to the interview with a housekeeper on 04/15/21 at 11:56.

Refer to the interview with a medication aide (MA) on 04/15/21 at 12:09pm.

Refer to the interview with the Administrator on 04/15/21 at 12:13pm.

Refer to the interview with a second medication

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aide on 04/15/21 at 3:49pm.

Refer to the interview with the RCC at 4:33pm.

Staff A who was working second shift on 03/14/21 was unavailable for an interview on 04/13/21, 04/14/21, 04/15/21 and 04/16/21.

3. Review of Resident #4's current FL-2 dated 11/23/20 revealed:
-Diagnoses included acute psychosis, bipolar disorder, cognitive impairment, dementia and intellectual disability.
-There was no documentation on orientation status.
-Resident #4 was ambulatory and verbally abusive.

Review of Resident #4's care plan dated 11/23/20 revealed she was independent with ambulation and transferring.

a. Review of an Accident/Incident Report for Resident #4 dated 12/01/20 revealed:
-The date/time of accident/incident was 12/01/20 at 5:15pm.
-Resident #4 walked out of the facility.
-Staff went out to locate her.
-911 was called and Resident #4 was assisted back to the facility by local law enforcement.
-Staff would continue to monitor her.
-Resident #4's mental health provider was contacted, and a message was left on the answering machine.
-A facility staff member spoke with Resident #4's guardian and informed her of the situation.

Review of a progress note for Resident #4 by a supervisor/medication aide (MA) dated 12/23/20 revealed Resident #4 "walked away sometimes."

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D 270	Continued From page 23 Review of a progress note for Resident #4 by the Resident Care Coordinator (RCC) dated 01/28/21 revealed Resident #4 had walked away from the facility at times and the staff had to escort her back. Review of a second progress note for Resident #4 by a supervisor/MA dated 02/27/21 revealed Resident #4 attempted to leave the facility at times. Observations of Resident #4 on 04/13/21 from 10:36am - 10:42am revealed: -At 10:36am, Resident #4 was observed to be sitting in a chair in the front lobby. -At 10:41am, Resident #4 exited the facility using the front lobby door, opened and closed the front lobby door 3 times in a row, slamming the door very loudly each time. -At 10:41am, the Administrator was observed to be standing outside of the facility and redirected Resident #4 back inside of the building. -At 10:42am, the Administrator and Resident #4 reentered the facility using the side entrance. Observations of Resident #4 on 04/13/21 from 11:05am - 11:08am revealed: -At 11:05am, Resident #4 exited the facility using the front lobby door and walked to the side entrance. -There were no facility staff present in the lobby or outside. -There were two residents sitting outside, near the side entrance. -At 11:08am, Resident #4 reentered the facility using the side entrance. Interview with the Secretary on 04/14/21 at 9:53am revealed:	D 270		

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-She worked as a personal care aide (PCA) and a supervisor.
-Resident #4 had a history of elopement.
-She completed an incident report for Resident #4's elopement on 12/01/20.
-On 12/01/20 at 5:15pm, Resident #4 walked out of the facility, unsure which door she exited from.
-The staff had gone out to look for Resident #4 and the police were contacted.
-Resident #4 was found on 12/01/20 walking down the street by the police and was escorted back to the facility.
-Resident #4's mental health provider and guardian were contacted and made aware of incident.
-She was not aware of any other elopements for Resident #4.
-She was not sure how many times Resident #4 had attempted to leave the facility.
-The staff were to monitor Resident #4's location every 30 minutes for safety and document on a rounding sheet.
-She would sometimes walk with Resident #4 throughout the facility to redirect her from the exit doors.
-She had observed Resident #4 exit one door of the facility and enter another door of the facility several times and did not think Resident #4 was exit seeking.
-She watched Resident #4 closely when she exited the facility to make sure she did not leave the facility grounds.
-There had been times when Resident #4 exited the facility and walked towards the parking lot, she would go outside and redirect Resident #4 inside the facility.
-There were alarms on all exit doors that sounded when the doors were opened.
-The alarms sounded until the staff disarmed them.

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-The alarm on the front door in the lobby was automatically turned off every day at 8:00am and turned on at 6:00pm by the staff.
-It was the responsibility of the supervisor to monitor the front lobby entrance during the hours of 8:00am and 6:00pm if the Administrator was not available.
-It was the responsibility of the staff to determine who opened the door and disarm the alarm.
-It was the responsibility of the supervisors and the Administrator to inform the staff of residents who were at an increased risk for elopement.
-Residents who were at an increased risk for elopement were discussed with new employees during the orientation process.
-The supervisors and the Administrators would inform the staff of new admissions who were at an increased risk for elopement.

Interview with a supervisor/medication aide (MA) on 04/15/21 at 12:09pm revealed:
-Resident #4 had a history of elopement behaviors.
-He would try to keep Resident #4 on the "back hall" where the fenced smoking area was.
-If Resident #4 was on the front hallway, she would exit out the front lobby doors that lead to the parking lot and go off the facility grounds.
-He checked on Resident #4 approximately every 15 minutes for safety.

Interview with the Administrator on 04/15/21 at 12:13pm revealed:
-Resident #4 was oriented to her name and surroundings with psychosis present.
-Resident #4 was an elopement risk but was not on increased supervision checks.
-Resident #4 "consistently" tried to enter and re-enter the facility.
-Resident #4 had walked out of the facility

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"previously" and "we" found her around the corner, no additional details give.
-If Resident #4 sensed someone was behind her, she would walk more quickly.
-Resident #4 had been found at the residential home across the street from the facility.
-Resident #4 was "safe" to sit outside the facility and she was "safe" to cross the street.
-She was not safe to leave the facility grounds.
-She initiated increased supervision checks every 30 minutes for Resident #4 on 04/15/21

Interview with a second supervisor/MA on 04/15/21 at 12:30pm revealed:
-She worked at the facility as needed.
-Residents at risk for elopement behaviors had documentation on their care plans for wandering behaviors.
-The supervisors and the Administrator provided information to the staff related to residents with elopement behaviors.
-The staff checked on residents every 2 hours for safety and ADL care.
-She checked Resident #4 every 15 minutes for safety; she did not document this safety check.
-There were door alarms that sounded at all exit doors that kept sounding until the staff reset them.
-If a resident was missing, it was the responsibility of the staff to check all of the rooms, bathrooms and the outside of the facility, then double check these same areas for the missing resident, notify the Administrator if the resident was still not located, call 911, call the transporter and other available staff to search surrounding areas, call the resident's responsible party, continue to look for resident, complete the accident/incident report, notify the provider of the incident and document the above in a progress note.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 27 Interview with a medication aide on 04/15/21 at 3:49pm revealed: -Residents #4 was at risk for elopement from the facility. -Residents #4 had tendencies to attempt to "walk away" from the facility. -Resident #4's current supervision intervention in place was every 2 hours staff rounds. -She was not aware of any other supervision interventions in place to present for Residents #4. Interview with the RCC on 04/16/21 at 4:33pm revealed: -Resident #4 was at risk for elopement from the facility. -Residents #4 was deemed to not be safe to walk to the store by herself, she did not know her last name. -Resident #4's current supervision in place was staff monitoring every 30 minutes, but she could not recall when this was initiated by the facility. Interview with the Administrator on 04/16/21 at 5:13pm revealed: -Resident #4 was identified as an elopement risk. -Residents #4 was deemed to not be safe to walk to the store by herself due to her confusion and her mental health history. -Supervision interventions in place were staff rounding every two hours. -Her supervision staff rounds were increased to every 30 minutes on 04/15/21. Based on observations, interviews and record reviews it was determined that Resident #4 was not interviewable. Attempted telephone interviews with Resident #4's primary care provider on 04/16/21 at	D 270		

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D 270	Continued From page 28 10:00am and 10:46am were unsuccessful. Attempted telephone interview with Resident #4's mental health provider on 04/16/21 at 10:05am was unsuccessful. Refer to the interview with the Secretary on 04/14/21 at 9:53am. Refer to the telephone interview with a local law enforcement officer on 04/15/21 at 11:15am. Refer to the interview with a housekeeper on 04/15/21 at 11:56. Refer to the interview with a medication aide (MA) on 04/15/21 at 12:09pm. Refer to the interview with the Administrator on 04/15/21 at 12:13pm. Refer to the interview with a second medication aide on 04/15/21 at 3:49pm. b. Observation of Resident #4 on 04/15/21 from 11:08am - 11:43am revealed: -At 11:08am, Resident #4 was observed walking without assisted device into the opened storage shed, at the back of the facility, inside the fenced area. -There were no staff present. -Resident #4 exited storage shed after being prompted by surveyor and began to walk away from the storage shed. -At 11:13am, Resident #4 was observed walking in front of the storage shed and was encouraged by surveyor not to enter. -There were no staff present. -At 11:15am, Resident #4 walked into the smoking hut and immediately exited at 11:15am.	D 270		

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-There were no staff present.
-At 11:17am, Resident #4 continued to walk near the smoking hut.
-At 11:18am, Resident #4 fell while walking and landed on her right side.
-There was a supervisor/medication aide (MA) in the smoking hut at that time and was made aware of the incident at 11:18am.
-At 11:19am, Surveyor alerted other staff in the facility of the incident for assistance.
-At 11:21am, a personal care aide (PCA) outside and assisted the supervisor/MA with Resident #4.
-The supervisor/MA reported that Resident #4 had complaints of headache and leg pain and that he was going to obtain equipment to check her vital signs.
-Resident #4 was lying flat on her back, near the smoking hut, no facial grimacing noted and no bleeding present.
-At 11:26am, the supervisor/MA returned to check Resident #4's blood pressure (B/P) and temperature and stated that 911 had been called.
-At 11:31am, Resident #4's B/P was 129/77mmhg, temperature was 96.2 and heart rate was 97.
-At 11:35am, emergency medical services (EMS) arrived at the facility and the Administrator escorted them to Resident #4.
-Resident #4 stated that she was "walking and fell" and indicated that her legs, arms and head were hurting.
-At 11:41am, Resident #4 stood from the ground and walked to the stretcher x2 assist.
-At 11:43am, Resident #4 exited the facility with EMS.

Observation of the storage shed on 04/15/21 from 11:08am - 11:56am revealed:
-The storage shed was in the opened position
-There were several mattresses, garbage bags

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D 270	Continued From page 30 full of items, a mechanical lift, several taped boxes with items inside and other miscellaneous items. Interview with a housekeeper on 04/15/21 at 11:56am revealed: -There was a sliding latch on the storage shed door, and when engaged, would prevent the shed door from lifting easily. -The sliding latch was engaged by sliding it to the right and disengaged by sliding it to the left. -When the sliding lock was disengaged, the storage shed door could be lifted. -There was a Padlock that locked onto the sliding lock; the sliding lock could not be disengaged without unlocking the Padlock. -The housekeeper, maintenance director and secretary had a key to the Padlock. -He did not unlock the shed on 04/15/21 and was not aware that the shed was unlocked and opened.-He was not sure who unlocked the shed on 04/15/21. -He did not know where the Padlock to the shed was located. Interview with a supervisor/MA on 04/15/21 at 12:09pm revealed: -The staff completed rounding every 2 hours that included the location of all residents. -He checked on Resident #4 approximately every 15 minutes for safety and documented on a facility rounding sheet. -He had last seen Resident #4 walking on the hallway near the fenced smoking area approximately 15 minutes prior to her fall. -He would try to keep Resident #4 on the "back hall" where the locked, fenced smoking area was located. -He was not aware that the storage shed was unlocked and opened.	D 270		

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-Maintenance and housekeepers had the key and unlocked the storage shed.
-There were alarms on all exit doors that sounded when the doors were opened.
-It was the responsibility of the staff to check the doors to see which resident entered or exited the facility before disarming the alarm.
-The alarm for the fenced smoking entrance door and the alarm for the lobby entrance door were turned off every day at 7:00am and turned on at 7:00pm.

Interview with the Administrator on 04/15/21 at 12:13pm revealed:
-Resident #4 was oriented to her name and surroundings with psychosis present.
-Resident #4 was an elopement risk but was not on increased supervision checks.
-Resident #4 "consistently" tried to enter and re-enter the facility.
-Resident #4 had walked out of the facility "previously" and "we" found her around the corner, no additional details give.
-If Resident #4 sensed someone was behind her, she would walk more quickly.
-Resident #4 had been found at the residential home across the street from the facility.
-Resident #4 was "safe" to sit outside the facility and she was "safe" to cross the street.
-She was not safe to leave the facility grounds.
-She initiated increased supervision checks every 30 minutes for Resident #4 on 04/15/21

Interview with a second supervisor/MA on 04/15/21 at 12:30pm revealed:
-The staff check on residents every 2 hours for safety and ADL care.
-She checked Resident #4 every 15 minutes for safety.
-There were door alarms that sounded at all exit

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doors and kept sounding until the staff reset them.

Interview with a medication aide on 04/15/21 at 3:49pm revealed:
-Residents #4 was at risk for elopement from the facility.
-Residents #4 had tendencies to attempt to "walk away" from the facility.
-Resident #4's current supervision intervention in place was every 2 hours staff rounds.
-She was not aware of any other supervision interventions in place to present for Residents #4.

Interview with the Resident Care Coordinator (RCC) on 04/16/21 at 4:33pm revealed:
-Residents #4 was deemed to not be safe to walk to the store by herself, she did not know her last name.
-Resident #4's current supervision in place was staff monitoring every 30 minutes, but she could not recall when this was initiated by the facility.

Interview with the Administrator on 04/16/21 at 5:13pm revealed:
-Resident #4 was identified as an elopement risk.
-Residents #4 was deemed to not be safe to walk to the store by herself due to her confusion and her mental health history.
-Supervision interventions in place were staff rounding every two hours.
-Her supervision staff rounds were increased to every 30 minutes on 04/15/21.

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

Attempted telephone interviews with Resident #4's primary care provider on 04/16/21 at

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D 270	Continued From page 33 10:00am and 10:46am were unsuccessful. Attempted telephone interview with Resident #4's mental health provider on 04/16/21 at 10:05am was unsuccessful. Refer to the interview with the Secretary on 04/14/21 at 9:53am. Refer to the telephone interview with a local law enforcement officer on 04/15/21 at 11:15am. Refer to the interview with a housekeeper on 04/15/21 at 11:56. Refer to the interview with a medication aide (MA) on 04/15/21 at 12:09pm. Refer to the interview with the Administrator on 04/15/21 at 12:13pm. Refer to the interview with a second medication aide on 04/15/21 at 3:49pm. Refer to the interview with the RCC on 04/16/21 at 4:33pm. _____ Interview with the Secretary on 04/14/21 at 9:53am revealed: -She worked as a personal care aide (PCA) and a supervisor. -There were alarms on all exit doors that sounded when the doors were opened. -The alarms sounded until the staff disarmed them. -The alarm on the front door in the lobby was automatically turned off every day at 8:00am and turned on at 6:00pm by the staff. -There was a camera located in the front lobby and there was a monitor in the Administrator's	D 270		

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office to monitor the camera activity.
-The Administrator would monitor the front lobby entrance during the hours of 8:00am and 6:00pm.
-It was the responsibility of the supervisor to monitor the front lobby entrance during the hours of 8:00am and 6:00pm if the Administrator was not available.
-It was the responsibility of the staff to determine who opened the door and disarm the alarm.
-It was the responsibility of the supervisors and the Administrator to inform the staff of residents who were at an increased risk for elopement.
-Residents who were at an increased risk for elopement were discussed with new employees during the orientation process.
-The supervisors and the Administrators would inform the staff of new admissions who were at an increased risk for elopement.

Telephone interview with a local law enforcement officer on 04/15/21 at 11:15am revealed:
-Facility staff members were never sure how long residents were gone from the facility.
-The timeline was "inconsistent" from one staff member to the next.
-Every time local law enforcement received a phone call concerning a missing resident, local law enforcement would automatically "double" the time reported by the facility staff member to estimate the length of time the resident left the facility.
-Local law enforcement received calls from the local business owners and home owners with reports of residents wandering in town, no additional details provided.
-He could not recall the date, but a resident was found in a home locally, had an incontinent episode within the home, and then the homeowner found the resident on their back porch.

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D 270	Continued From page 35 -He had tried to work out a compromise with the Administer to send a facility staff to retrieve "supplies" for the residents to decrease in the residents' daily trips to the local store. -Calls related to missing residents, staff to resident alterations, and resident to resident alterations from the facility had increased over the past year. Interview with a medication aide (MA) on 04/15/21 at 12:09pm revealed: -The Administrator informed staff the staff of residents that were elopement risks. -Residents were required to sign out prior to leaving the facility. -If residents were able to sign out, they were able to leave the facility and were not required to let the staff know prior to their departure. -The staff completed rounding every 2 hours that included the location of all residents. -It was the responsibility of the staff to check the sign out logs during rounding to determine which residents have signed out. -If a resident has not returned within 2 hours after signing themselves out of the facility, the staff would search the facility and the facility grounds for the resident; if not found, the police would be notified, and local areas would be searched. -If a resident had not signed out and is not found during routine rounding, then the staff would search the facility. -After the facility was searched and the resident was not found, 911 would be notified, the local areas would be searched, and the responsible party would be notified. -There were alarms on all exit doors that sounded when the doors were opened. -It was the responsibility of the staff to check the doors to see which resident entered or exited the facility before disarming the alarm.	D 270		

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-The alarm for the fenced smoking entrance door and the alarm for the lobby entrance door are turned off every day at 7:00am and turned on at 7:00pm.

Interview with the Administrator on 04/15/21 at 12:13pm revealed:
-The facility's policy for supervision of the residents was to complete walking rounds every 2 hours.
-She expected staff to walk into the resident's room and verify the resident's location.
-The staff was expected to verify if the resident was breathing or did the resident need something to drink.
-Every staff working first, second, or third shift were expected to complete the rounding sheets.
-The Resident Care Coordinator (RCC) and herself "tried" to audit the resident rounding sheets weekly.
-The RCC audit resident rounding sheets last week (week of 04/05/21).
-Staff were made aware of residents who identified as elopement risks during shift report.
-Staff who worked first, and second shift meet daily at 3:00pm.
-Staff who worked second, and third shift meet daily at 11:00pm.
-Staff who worked third, and first shift meet daily at 7:00am.

Interview with a second medication aide (MA) on 04/15/21 at 12:30pm revealed:
-Residents at risk for elopement behaviors had documentation on their care plans for wandering behaviors.
-The supervisors and the Administrator provided information to the staff related to residents with elopement behaviors.
-The staff checked on all residents every 2 hours

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for safety and ADL care.
-There were door alarms that sounded at all exit doors that kept sounding until the staff reset them.
-If a resident was missing, it was the responsibility of the staff to check all of the rooms, bathrooms and the outside of the facility, then double check these same areas for the missing resident, notify the Administrator if the resident was still not located, call 911, call the transporter and other available staff to search surrounding areas, call the resident's responsible party, continue to look for resident, complete the accident/incident report, notify the provider of the incident and document the above in a progress note.

Interview with a housekeeper on 04/15/21 at 11:56 revealed:
-The Administrator would let the staff know which residents were at risk for elopement.
-The elopement policy was reviewed during the new hire orientation.
-He was not sure how often residents were monitored by clinical staff.
-If he observed someone going off the facility grounds that was considered an elopement risk, he would redirect them back to the facility.
-There were alarms that sounded on all the exit doors, except the back door to the fenced smoking area.
-The exit door in the front lobby was locked after 6:00pm.
-He was not sure what time the door was unlocked, but it was unlocked when he reported to work at 7:00am.
-If a resident eloped, it was the responsibility of all staff to search inside and outside the facility.
-He would search for missing residents in the surrounding areas.

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D 270	Continued From page 38 Interview with a medication aide on 04/15/21 at 3:49pm revealed: -The facility's current supervision policy was to complete rounds on all residents every two hours. -When completing their resident rounds every two hours, staff would verify the location of the resident. -Every staff member working the assigned shift was responsible to complete the facility's rounding sheet every two hours which included staff's initials and resident's location. Interview with the RCC on 04/16/21 at 4:33pm revealed: -The facility's current supervision policy was to complete rounds on all residents every two hours. -When completing their resident rounds every two hours, staff would verify the location of the resident. -The staff rounding sheets included the staff initials, date, time, -A list of residents at risk for elopement from the facility was kept on a clipboard within the facility's medication room. -She was responsible to audit the staff rounding sheets. -The last she audited the staff rounding sheets was yesterday, 04/15/21. -She had not had a chance to audit the staff rounding sheets today, 04/16/21. _____ The facility failed to ensure 3 of 9 residents were supervised according to their needs. The facility's failure to supervise these residents resulted in: Resident #16's elopement from the facility on 12/25/20 in which he robbed a gas station, threatened to kill another person, had a physical altercation while attempting to carjack a truck, and was found by local law enforcement on the	D 270		

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D 270	Continued From page 39 corner in an altered state, had incoherent speech, and was observed to attempt to open the door of the local law enforcement's car which was already open. Resident #13's eloped from the facility on 12/29/20 in which a police officer observed him to be walking alone in the middle of the night and while the police officer was gathering information from Resident #13, the facility called in a missing person's report on him; Resident #13 had a second elopement on 03/14/21 in which he had managed to leave the facility and travel about approximately 12-15 miles from the facility to a surrounding town and when local law enforcement arrived on scene, he was only able to provide his name, and was under the influence of alcohol; Resident #4 had an elopement on 12/01/20 in which she walked away from the facility and local law enforcement had to bring her back to the facility; Resident #4 also walked into an unlocked storage shed outside the facility on 04/15/21. The facility's failure to provide supervision to the residents resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 27, 2021.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 271		

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D 271	Continued From page 40 (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff for 2 of 7 sampled residents (#12 and #6) in accordance with the facility's policies and procedures, which included a resident who had 2 falls with possible head injuries (#6) and a resident (#12) found by staff not breathing and without a pulse requiring cardiopulmonary resuscitation (CPR). The Findings are: 1.Review of Resident #6's current FL-2 dated 02/25/21 revealed diagnoses included atrial fibrillation, cerebral vascular accident (CVA), schizophrenia, and depression. Review of Resident #6's care plan dated 02/25/21 revealed: -The resident required extensive assistance with toileting, ambulation, and transfers. -The resident was totally dependent for bathing, dressing and grooming. Review of a facility's accident/incident report for Resident #6 dated 04/03/21(no time documented)	D 271		

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revealed:
-The resident was found sitting on the floor.
-The resident was checked for cuts, bruises, and in juries and none were found.
-The resident was "escorted" to the emergency room (ER) for further medical evaluation.
.
Review of a local law enforcement officer report dated 04/03/21 revealed:
-On 04/03/21 around 9:44pm, law enforcement responded to a call from the facility in reference to a person check welfare call.
-Upon arriving to the facility, the officers made contact with the facility's MA and 2 personal care aides (PCA).
-The officers were advised by the PCAs Resident #6 had fallen off his bed earlier around 7:00pm and was "bad off" and was not acting himself.
-When the officer asked the MA about nature of the resident's fall, she was quick to dismiss any points (suggestions) that Resident #6 needed to be checked out by EMS.
-The resident's roommate said he believed Resident #6 needed medical attention because he was not behaving like himself and had fallen off the bed earlier in the day and knocked the bedside table drawers out.
-It was implied he could have possibly hit his head due to the way the resident seemed incoherent and was not really able to answer questions.
-The officer determined Resident #6 should be checked out by EMS.
-The officer found the MA who was in an office talking on the phone and advised her he was going to call EMS to check on the well-being of the Resident.
-EMS arrived at the facility a few minutes later and was advised by the officers the Resident #6 was in very poor health and needed to be

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evaluated.
-The resident was transported to the local ER via EMS

Review of an emergency medical service (EMS) report dated 04/03/21 revealed:
-Medics were dispatched to the facility at 10:12pm after receiving a call regarding a fall victim at the facility.
-EMS arrived at the facility at 10:23pm and Resident #6 was lying in his bed in no distress but his skin was hot to touch.
-Facility staff informed EMS the resident had not been as active as normal and fallen a few hours ago possibly striking has head but was not evaluated by anyone nor was the PCP contacted.
-The resident was transported to the local ER and arrived at 11:00pm.

Review of a local hospital admission report for Resident #6 revealed:
-The resident was transported to the emergency room (ER) via EMS on 04/02/21 and was currently hospitalized.
-He was accompanied to the ER by a facility staff who reported the resident had fallen out of bed earlier and had not been himself for the last 2 days.
-Resident #6 was unresponsive in the ER and his Glasco Coma Scale score was 9 (which indicated moderate brain injury)
- The resident was intubated, place on mechanical ventilation for life support and transferred to the intensive care unit (ICU).
-The resident's dorsal aspect (back) of his left hand had some redness and a red streak that extended up to the forearm.
-CT scan of the resident's abdomen/pelvis revealed age-indeterminate compression fractures (unable to determine the time the

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fracture occurred) of the T8 and T10 vertebrae.
-Other admission diagnoses included sepsis, septic shock, altered mental status, acute respiratory failure, atrial fibrillation and non-traumatic rhabdomyolysis (a condition in which skeletal muscle breaks down rapidly and lead to kidney failure), pneumonia with mild atelectasis (lung collapse) at base of right and left lungs, and cellulitis of the left hand
- The resident was intubated, place on mechanical ventilation for life support, placed in a chemically induced coma, transferred to the intensive care unit (ICU) and intravenous (IV) antibiotics were started.
-A blood culture for Resident #6 was positive for gram-positive cocci (a bacterial infection)
-The resident's prognosis was very poor at time of admission.

Review of facility progress notes for Resident #6 revealed:
-On 04/03/21 the medication aide (MA) was "making rounds" and checked on Resident #6 and found him on the floor.
-Staff assisted the resident onto his bed and the MA checked him for cuts, bruises, and injuries but none were found.
-The MA checked the resident for cuts, bruises, and injuries, none were found, and the resident stated he was not hurting.
-Two local law enforcement officer entered the facility and checked on Resident #6.
-The officer stated they were called by someone inside of the facility who informed them Resident #6 was had a medical need and no one was addressing it.
-The officers informed the MA they had called emergency medical service (EMS) and left the facility when EMS arrived and transported Resident #6 to the local hospital.

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-The resident's primary care provider (PCP) and his family was notified.

Interview with the facility's 2nd shift supervisor/ medication aide (MA) on 04/13/21 at 3:40pm revealed:
-She was working on 04/02/21 and 04/03/21 when Resident #6 was found on the floor.
-On 04/02/21 after dinner, Resident #6 was found on the floor in his room, but the resident was not transported to the ER for evaluation because she reported the fall to his PCP.
-On 04/03/21 at approximately 7:00pm, Resident #6 was found on the floor with his head against the nightstand beside his bed.
-The resident was assisted back into his bed by 2 personal care aides (PCA) and she checked the resident for injuries.
-About 2 hours later, 2 local law enforcement officers arrived at the facility and informed the MA that they received a call from inside the facility to check on Resident #6.
-The officers went to Resident #6's room to check on him and called EMS to take him to the local ER.
-EMS arrived at the facility about 15 minutes later and transported the resident to the local ER and the resident was admitted to the hospital.
-The MA was aware the resident's status had changed about 3 days before and was not as responsive and was weak.
-The facility's fall policy was: if a resident fell or was found on the floor, the MA checked the resident for injury, report the fall to the primary care provider (PCP) and send the resident to the ER if suspected injury or if the resident hit his/her head.
-The MA called the PCP and notified him of both falls and he instructed her to schedule an office visit on Monday (04/05/21).

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D 271	Continued From page 45 Interview with Resident #6's roommate on 04/14/21 at 9:40am revealed: -Resident #6 had become weaker and pale and require assistance with transfers 3 days before he was hospitalized. -Resident #6 fell out of bed on 04/02/21 (after dinner) and hit his head on the bedside table but was not sent to the ER after the fall. Staff assisted the resident back to bed. -Resident #6 was sitting up in bed and fell out of bed again on 04/03/21 (after dinner). -The roommate heard a loud bang and observed the resident on the floor with his head against the bedside table. -The roommate called for help and the MA checked the resident and 2 other staff assisted the resident back in bed. -The resident looked very weak and "sick" and the other 2 staff who were personal care aides (PCA) tried to get the MA to call EMS to check the resident and transport him to the ER but the MA told them she was the "boss" and would do what she wanted. She refused to call EMS. -Two law enforcement officers were called to the facility and talked to the MA about getting Resident #6 "help". -The MA told the law enforcement officers Resident #6 was under her control and refused to call EMS. -The law enforcement officers requested Resident #6's medical records and called EMS Telephone interview with the clinical manager at Resident #6's PCP office on 04/14/21 at 10:20am revealed: -There was no documentation of calls from the facility on 04/02/21 or 04/03/21. -There was not a scheduled appointment for Resident #6 on 04/05/21 or any other date in April	D 271		

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2021.
-The only call from the facility was to report the resident was admitted to the hospital and was in the intensive care unit (ICU).

Telephone call to a former personal care aide (PCA) on 04/14/21 at 3:45pm revealed:
-On 04/03/21 Resident #6 weaker and was not as alert during dinner, has skin color was pale.
-Around 7:30pm on 04/03/21, Resident #6's roommate stepped out in the hall and told the MA that Resident #6 had fallen out of bed.
-She went to the resident's room and he was on the floor and his head was against the bedside table.
-There was a male staff in the room with the MA and she was told to leave the room.
-When the MA came out of the resident's room, she stated Resident #6 was doing better.
-When she checked on the resident at 8:15pm, he was in bed and had runny diarrhea stool in the bed.
-She and a 2nd PCA cleaned him up and she noted the resident was cold to touch, pale and his breathing was shallow.
-The resident's roommate told the former staff that Resident #6 had fallen on 04/02/21 and 04/03/21 and had hit his head on the bedside table both days.
-She reported the changes to the MA and told her Resident #6 needed to be sent out to the ER.
-The MA refused to call EMS and stated she had reported the fall to the Administrator.
-The 2nd PCA was concerned about Resident #6 and called 911 at 9:15pm.
-Two local law enforcement officers arrived at the facility a few minutes later and stated they were called by someone at the facility to come to the facility to do a wellness check for Resident #6.
-The 2nd PCA and she walked with the officers

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to Resident #6's room and the resident was "out of it" and unable to answer the officers' questions.
-The officer called EMS to come to the facility to check Resident #6.
-When the officers informed the MA that EMS had been called, she became argumentative with them.
-The paramedics arrived at the facility a few minutes later, checked the resident and informed staff he had a low grade temperature and his blood sugar was high and he was likely septic.
-The resident was transported to the local ER by EMS and was admitted to the hospital.
-She drove separately to the ER with the resident.
-The resident was intubated and transferred to the ICU.

Attempted interview with the 2nd PCA on 04/15/21, but the PCA was not available for interview.

Telephone interview with Resident #6's PCP on 04/15/21 at 2:50pm revealed:
-The facility did not call him on 04/02/21 or 04/03/21 to report Resident had fallen or to report a status change.
-He expected the facility to call him to report the falls and change in status.
-The PCP was available 24 hours a day/7 days a week for the facility to call for resident status changes/accidents.
- If the facility would have called him to report the resident had fallen out of bed and possibly hit his head and there was a change in his status such as decreased consciousness and weakness, he would have given the facility instructions to send the resident to the ER for evaluation.

Telephone interview with Resident #6's family member on 04/13/21 at 9:30am revealed:

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-The facility did not call her or any other family to report the resident had fallen or that the resident was admitted to the hospital.
-She received a call from the hospital on 04/03/21 and was told the resident was septic and was transferred to the ICU.

Interview with the Administrator on 04/16/21 at 5:25pm revealed:
-She was not aware Resident #6 had fallen on 04/02/21 and 04/03/21.
-If a resident fell, she expected the MAs to check the resident's vital signs, check for injuries and call the resident PCP immediately to report the fall.
-If the fall was unwitnessed or if there was a suspected head injury or injury of any kind, staff should call EMS and the resident transported to the local ER for evaluation.
-According to the facility's fall policy, if a resident fell and there was not a suspected injury; no changes in the resident's status, the resident was seen by the PCP the following day. But falls with suspected injury or unwitnessed falls, the MA assessed the resident and called EMS to transport to the ER for evaluation.

2. Review of Resident #12's current FL-2 dated 04/18/20 revealed:
-Diagnoses included dementia, unresponsiveness, syncope, Parkinson's disease, cardiomyopathy, depression, and prone to falls.
-The resident was intermittently disoriented.
-The resident was non ambulatory and used of a wheelchair.

Review of Resident #12's current assessment and care plan dated 04/22/20 revealed:
-The resident was sometimes disoriented, forgetful, and needed reminders.

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D 271	Continued From page 49 -The resident was totally dependent on staff for bathing, ambulation, dressing, grooming and transferring. Review of Resident #12's record revealed: -There was an unlabeled form listing the residents' allergies and "FULL CODE" in large print. -There was a line for "physician" and "sign and date" that was blank. Review of an Accident/Incident report for Resident #2 dated 02/13/21 revealed: -The time of the incident was on 02/13/21 at 5:10am. -Notification was made to the responsible person on 02/13/21 at 5:30am. -There was documentation "staff" were making rounds and checked on the resident. -The resident was not breathing, staff checked for a pulse, none found, "staff" started CPR (cardiopulmonary resuscitation) and called 911 for assistance, the resident's primary care provider (PCP) was notified and the PCP pronounced the resident deceased. -The Resident Care Coordinator (RCC) signed the form as the staff completing the Accident/Incident report. Interview with the Administrator on 04/14/21 at 12:38pm revealed staff were trained in CPR and first aid. Review of a local county emergency medical service (EMS) incident report dated 02/13/21 revealed: -At 5:46am, local EMS was dispatched to the facility for Resident #12 as "emergent (immediate response)", cardiac arrest. -In the "Scene Information" section of the form,	D 271		

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the resident was lying in bed on the right side, "hands purple".
-The chief complaint was cardiac arrest with an acronym entered as "DOA" (Dead on arrival).
-In the history of present illness section, there was an entry the medics were dispatched to an unresponsive male in the bed in his room.
-Staff reported the resident was last seen breathing at 3:00am when the resident was checked on and "he wasn't looking well".
-The staff came back at 5:10am, and the resident was not breathing at all.
-The staff reported that "she tried to before [sic] CPR but could not".
-The resident's hands were purple and the skin was pale.
-The resident was lying on his right side, no pulse, no respirations, no signs of life.
-The resident had expired without resuscitation efforts.
-The time of death was 5:57am.

Review of the facility's staff schedule dated 02/13/21 revealed:
-There were four staff members listed as working third shift from 11:00pm -7:00am on 02/13/21.
-There was a fifth staff, a medication aide (MA) who worked from 11:00am - 11:15pm.

Interview with a PCA documented as working third shift on 02/13/21 on 04/15/21 at 9:35pm revealed:
-He was not working third shift on 02/13/21.
-He remembered he worked second shift a on 02/13/21 and recalled Resident #12 being the same with no changes noted during his shift.
-He thought at the end of his shift he last checked on the resident around 11:15pm just before he left the facility.

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Interview with the Resident Care Coordinator (RCC) on 04/16/21 at 5:24pm revealed:
-She wrote the Accident/Incident report for Resident #12 dated 02/13/21 probably because the MA working on 02/13/21 was not a Supervisor.
-Only a MA/supervisor could complete an Accident/Incident report for the residents at the facility.
-She obtained the information documented on Resident #12's Accident/Incident report from the staff that provided the residents care on 02/13/21.
-She could not recall who was working third shift on 02/13/21.
-She could not recall the name of the employee who provided the detailed information when resident passed away.
-The occurrence times documented on Resident #12's Accident/Incident report was provided by the staff caring for Resident #12.
-She had not received or reviewed the local county emergency medical service (EMS) incident report dated 02/13/21 for Resident #12.
-She had concerns that Resident #12 was checked on at 3:00am and "he wasn't looking well".
-She had concerns why Resident #12 was not checked on sooner than 2 hours if there was a noted change in the resident.
-If Resident #12 wasn't looking well at 3:00am then the resident's primary care provider (PCP) should have been notified or the resident should have been sent out to the emergency room (ER) for evaluation.
-She was not sure why she would receive information from staff that CPR was initiated, and EMS documented "she tried to before [sic] CPR but could not".
-She was not sure why Resident #12 was found by EMS lying on his right side because if CPR

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was performed by staff then the resident should have been lying on his back.
-She was not sure why staff indicated the time of the incident was at 5:10am and the EMS was dispatched to the facility 36 minutes later at 5:46am.
-One staff should have been performing CPR while another staff called 911 for assistance.

Interview with the Administrator on 04/16/21 at 6:00pm revealed:
-She was not sure who worked third shift on 02/13/21 but would continue to look for additional information.
-She thought she remembered a named PCA that might have worked and who was not listed on the schedule dated 02/13/21 but was not sure.
-The fourth person assigned on the scheduled for third shift on 02/13/21 was a PCA, however no longer worked at the facility and she did not have the PCAs telephone contact number.
-She expected staff to have made attempts to contact Resident #12's PCP or sent the resident for evaluation in the ER when there were concerns the resident was not looking well at 3:00am.
-Staff should have checked on Resident #12 more frequently than every 2 hours with a noted change in status.
-She had questions and concerns why Resident #12 was lying on his right side, not on the floor on a hard surface while performing CPR.

At the time of exit there was no additional information provided identifying the staff who worked third shift on 02/13/21.

Attempted telephone interview with the EMS crew dispatched to the facility on 02/13/21 for Resident #12 was unsuccessful on 04/15/21 at 11:25am,

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D 271	Continued From page 53 3:14pm and 4:09pm and 04/16/21 at 10:22am and 2:17pm. _____ The facility failed to immediately respond the emergency needs for 2 of 7 sampled residents (#6 and #12) who sustained 2 falls out of bed in 24 hours (#6) with suspected head injuries and EMS was not called until the local law enforcement officers were called to the facility and called EMS to transport the resident to the local ER where the resident was intubated and placed on a mechanical ventilator and transferred to ICU for critical care; and failed to contact 911 immediately for assistance with a 36 minute recorded delay from the time EMS was dispatched to the facility from the time Resident #12 was observed by staff not breathing and had no pulse and documentation by EMS that staff had attempted CPR however did not perform. EMS documentation reflected Resident #12 was dead without resuscitation efforts and was pronounced deceased 1 minute after EMS arrived to the resident. The facility's failure to respond immediately resulted in serious harm and neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 04/14/21. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 27, 2021.	D 271		
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D 273	Continued From page 54 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure health care referral and follow-up for 5 of 7 sampled residents (#1, #3, #5, #6, and #12) related to not reporting acute health care changes in a resident who was later hospitalized in the intensive care unit (ICU) related to septic shock and placed on mechanical ventilation (#6); a hip wound was not reported the PCP and progressed to an open draining wound (#12), an order for a stool-DNA screening test (#3, #1), a resident who complained of left upper extremity pain after being dropped by staff (#5), and a resident who had an order for a mammogram and eye exam (#1). The findings are: 1.Review of Resident #6's current FL-2 dated 02/25/21 revealed diagnoses included atrial fibrillation, cerebral vascular accident (CVA), schizophrenia, and depression. Review of Resident #6's care plan dated 02/25/21 revealed: -The resident required extensive assistance with toileting, ambulation, and transfers. -The resident was totally dependent for bathing, dressing and grooming. Review of a facility's accident/incident report for Resident #6 dated 04/02/21 revealed: -The resident was looking pale and having trouble	D 273		

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feeding himself.
-The resident's vital signs were checked, and he had a low-grade fever (not documented) and Tylenol 650mg was administered for fever.
-Resident #6's primary care provider was called, and instructions were given to monitor him, give Tylenol for fever, and push fluids and the PCP would see him on Monday (04/05/21).
-If the resident's fever was above 101 and he had trouble breathing, send him to the local emergency room (ER).

Review of facility progress notes dated 04/02/21(3:00pm-11:00pm shift) for Resident #6 revealed:
-Resident #6 was looking pale and having trouble feeding himself.
-Staff checked the resident's vital signs and he was running a low-grade fever Tylenol 650mg was given for the fever.
-Resident #6's PCP was called, and he said to monitor the resident, give Tylenol for fever, push fluids and he would see the resident on Monday.
-If the resident's temperature was over 101 and he had trouble breathing, send him to the ER

Review of a facility's accident/incident report for Resident #6 dated 04/03/21 revealed:
-The resident was found sitting on the floor.
-The resident was checked for cuts, bruises, and in juries and none were found.
-The resident was "escorted" to the emergency room (ER) for further medical evaluation.

Review of a local law enforcement officer report dated 04/03/21 revealed:
-On 04/03/21 around 9:44pm, law enforcement responded to a call from the facility in reference to a person check welfare call.
-Upon arriving to the facility, the officers made

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contact with the facility's MA and 2 personal care aides (PCA).
-The officers were advised by the PCAs Resident #6 had fallen off his bed earlier around 7:00pm and was "bad off" and was not acting himself.
-When the officer asked the MA about nature of the resident's fall, she was quick to dismiss any points (suggestions) that Resident #6 needed to be checked out by EMS.
-The resident's roommate said he believed Resident #6 needed medical attention because he was not behaving like himself and had fallen off the bed earlier in the day and knocked the bedside table drawers out.
-It was implied he could have possibly hit his head due to the way the resident seemed incoherent and was not really able to answer questions.
-The officer determined Resident #6 should be checked out by EMS.
-The officer found the MA who was in an office talking on the phone and advised her he was going to call EMS to check on the well-being of the Resident.
-EMS arrived at the facility a few minutes later and was advised by the officers the Resident #6 was in very poor health and needed to be evaluated.
-The resident was transported to the local ER via EMS.

Review of an emergency medical service (EMS) report dated 04/03/21 revealed:
-Medics were dispatched to the facility at 10:12pm after receiving a call regarding a fall victim at the facility.
-EMS arrived at the facility at 10:23pm and Resident #6 was lying in his bed, in no distress, alert but his skin was hot to touch.
-Facility staff reported the resident had not been

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active was his normal.
-Facility staff informed EMS the resident had not been as active as normal and fallen a few hours ago possibly striking has head but was not evaluated by anyone nor was the PCP contacted.
-The medication aide (MA) reported Resident #2 had been running a temperature the last 2 days and had not been given Tylenol or ibuprofen.
-Resident #6's temperature was 100.4 degrees Fahrenheit and his blood sugar reading was 239 (normal blood sugar levels for non-diabetics are 70 - 100 mg/dL).
-The resident was transported to the local ER and arrived at 11:00pm.

Review of a local hospital admission report for Resident #6 revealed:
The resident was transported to the emergency room (ER) via EMS on 04/02/21 and was currently hospitalized.
-He was accompanied to the ER by a facility staff who reported the resident had fallen out of bed earlier, had a low-grade fever and had not been himself for the last 2 days.
-The resident mental status had been altered for 2 days and he was not eating much.
-At presentation in the ER, the resident had some emesis (vomit) on his shirt.
-Resident #6 was unresponsive in the ER and his Glasco Coma Scale score was 9 (which indicated moderate brain injury).
-The resident's dorsal aspect (back) of his left hand had some redness and a red streak that extended up to the forearm.
-CT scan of the resident's abdomen/pelvis revealed age-indeterminate compression fractures of the T8 and T10 vertebrae.
-Other admission diagnoses included sepsis, septic shock, altered mental status, acute respiratory failure, atrial fibrillation and

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non-traumatic rhabdomyolysis (a condition in which skeletal muscle breaks down rapidly and lead to kidney failure), pneumonia with mild atelectasis (lung collapse) at base of right and left lungs, and cellulitis of the left hand
- The resident was intubated, place on mechanical ventilation for life support, placed in a chemically induced coma, transferred to the intensive care unit (ICU) and intravenous (IV) antibiotics were started.
-A blood culture for Resident #6 was positive for gram-positive cocci (a bacterial infection)
-The resident's prognosis was very poor at time of admission.

Review of facility progress notes (the first note documented) dated 04/03/21 (3:00pm - 11:00pm shift) for Resident #6 revealed:
-When making rounds and checked on Resident #6, the MA noticed the resident was not talking as much as he usually did.
-The resident report he was constipated and when the MA checked the resident's stomach, it felt hard.
-The resident's temperature was 99.7 and the MA called the resident's PCP and reported the changes.
-The PCP gave instructions to administer 2 Tylenol for the fever and 2 Dulcolax tablets with a cup of hot coffee; continue to monitor the resident and bring him into the medical office on Monday (04/05/21).
-If the resident's fever rose above 100 degrees F. to send him to the ER

Review of facility progress notes (the second note documented) dated 04/03/21 (3:00pm-11:00pm shift) for Resident #6 revealed:
-The medication aide (MA) was "making rounds" and checked on Resident #6 and found him on

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the floor.
-Staff assisted the resident onto his bed and the MA checked him for cuts, bruises, and injuries but none were found.
-The MA checked the resident for cuts, bruises, and injuries, none were found, and the resident stated he was not hurting.
-Two local law enforcement officer entered the facility and checked on Resident #6.
-The officer stated they were called by someone inside of the facility who informed them Resident #6 was had a medical need and no one was addressing it.
-The officers informed the MA they had called emergency medical service (EMS) and left the facility when EMS arrived and transported Resident #6 to the local hospital.
-The resident's primary care provider (PCP) and his family was notified.

Telephone interview with the clinical manager at Resident #6's PCP office on 04/14/21 at 10:20am revealed:
-There was no documentation of calls from the facility on 04/02/21 or 04/03/21.
-There was no documentation of any calls from the facility to report Resident #6 was constipation and there was no documentation of an order to administer any laxatives.
-If the facility called the PCP after office hours or on the weekend, the PCP would give verbal/telephone orders and the facility would send the orders to the office for the PCP to review and sign.
-There was not a scheduled appointment for Resident #6 on 04/05/21 or any other date in April 2021.
-The PCP only seen the resident once at the office on 02/25/21(a new patient visit).
-The only call from the facility was to report the

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resident was admitted to the hospital and was in the intensive care unit (ICU).

Telephone interview with Resident #6's PCP on 04/15/21 at 2:50pm revealed:
-The facility did not call the PCP to report Resident #6's stomach was hard/distended, that the resident was pale or weaker or the resident had fallen or any status change.
-If the facility reported the resident's abdomen was distended/hard, he would have directed the facility to send him to the ER for evaluation because stomach problems could have been an indication of infection/sepsis.
- If the facility would have called him to report the resident had fallen out of bed and possibly hit his head and there was a change in his status such as decreased consciousness and weakness, he would have given the facility instructions to send the resident to the ER for evaluation.
-The only report he received from the facility's RCC who reported Resident #6 was hospitalized.
-He expected the facility to call him as soon as possible/immediately to report any change in status.
-The PCP was available 24 hours a day/7 days a week and he had instructed the facility to call him at home (his personal phone number) for any residents who had status changes/accidents.

Interview with the facility's 2nd shift supervisor/medication aide (MA) on 04/13/21 at 3:40pm revealed:
-She worked second shift (3pm - 11pm) was worked on 04/02/21 and 04/03/21.
-On 04/03/21 when she was making rounds, she asked the resident if he was okay, but the resident did not respond as usual but did complain being constipation.
-She checked the resident and his stomach was

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hard and his temperature was 99.7 degrees F.
-She called the resident's PCP who instructed her to administer Dulcolax with a cup of coffee and Tylenol was administered for his fever.
-On her next round the resident was feeling better
-On 04/03/21 at approximately 7:00pm, Resident #6 was found on the floor with his head against the nightstand beside his bed.
-The resident was assisted back into his bed by 2 personal care aides (PCA) and she checked the resident for injuries.
-About 2 hours later, 2 local law enforcement officers arrived at the facility and informed the MA that they received a call from inside the facility to check on Resident #6.
-The officers went to Resident #6's room to check on him and called EMS to take him to the local ER.
-EMS arrived at the facility about 15 minutes later and transported the resident to the local ER and the resident was admitted to the hospital.
-The MA was aware the resident's status had changed about 3 days before and was not as responsive and was weak.
-The facility's fall policy was: if a resident fell or was found on the floor, the MA checked the resident for injury, report the fall to the primary care provider (PCP) and send the resident to the ER if suspected injury or if the resident hit his/her head.
-The MA called the PCP and notified him of both falls and he instructed her to schedule an office visit on Monday (04/05/21).
-She did not recheck the resident before EMS arrived and did not send the resident to the ER because the resident's PCP wanted to see him at his office on 04/05/21.

Interview with Resident #6's roommate on 04/14/21 at 9:40am revealed:

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-Resident #6 had become weaker and pale, required assistance with transfers, and had trouble feeding himself 3 days before he was hospitalized.
-Resident #6 fell out of bed on 04/02/21 and 04/03/21(after dinner) and hit his head on the bedside table but was not sent to the ER after the fall. Staff assisted the resident back to bed.
-The resident was sitting up in bed and because he was weak and "out of it", he had trouble had trouble sitting up and keep felling over and finally fell out of bed.
-The resident looked very weak and "sick" and the other 2 staff who were personal care aides (PCA) tried to get the MA to call EMS to check the resident and transport him to the ER but the MA told them she was the "boss" and would do what she wanted. She refused to call EMS.
-Two law enforcement officers were called to the facility about 2 hours after the resident fell and talked to the MA about getting Resident #6 "help".
-The MA told the law enforcement officers Resident #6 was under her control and refused to call EMS.
-The law enforcement officers requested Resident #6's medical records and called EMS
-The "head" MA was not going to call EMS to get Resident #6 help, but the 2 other staff called for help.
-If they had not called, Resident #6 would have probably died before morning, because he had been sick for 3 days and was getting much sicker and no one was helping him.

Telephone interview with a former personal care aide (PCA) on 04/14/21 at 3:45pm revealed:
-On 04/03/21 about 30 minutes after her shift started, she knew Resident #6 needed to be sent to the ER for evaluation.
- Resident #6 was weaker and was not as alert

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during dinner, his skin color was pale, and he was slumped down and leaning over in his wheelchair.
-The resident was normally alert and talkative, but he was not himself, he normally transferred himself from the wheelchair to his bed but he was very weak and required assistance.
-After she took the resident to his room and assisted him into his bed, she checked the resident's vital signs and his temperature was over 99 degrees F and his oxygen saturation level was 89%.
-She reported the resident's temperature and oxygen level to the MA and informed her the resident was not acting himself.
-The MA told her not to do her (the MA) job and she had spoken to the Administrator earlier who directed her not to send Resident #6 to ER.
-Around 7:30pm on 04/03/21, Resident #6's roommate stepped out in the hall and told the MA that Resident #6 had fallen out of bed.
-She went to the resident's room and he was on the floor and his head was against the bedside table.
-There was a male staff in the room with the MA and she was told to leave the room.
-When the MA came out of the resident's room, she stated Resident #6 was doing better.
-When she checked on the resident at 8:15pm, he was in bed and had runny diarrhea stool in the bed.
-She and a 2nd PCA cleaned him up and she noted the resident was cold to touch, pale and his breathing was shallow and runny diarrhea and urine was continuously flowing.
-She observed when the resident breathed, his mouth and jawline were sucked inward; he was having difficulty breathing.
-The resident's roommate told the former staff that Resident #6 had fallen on 04/02/21 and 04/03/21 and had hit his head on the bedside

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D 273	Continued From page 64 table both days. -She reported the changes to the MA and told her again that Resident #6 needed to be sent out to the ER. -The MA refused to call EMS and stated she had reported the fall to the Administrator, but the MA never stated she had called the resident's PCP. -The 2nd PCA was also concerned about Resident #6 and called 911 at 9:15pm and asked for the local law enforcement officer to come to the facility to check on the resident. -Two local law enforcement officers arrived at the facility a few minutes later and stated they were called by someone at the facility to come to the facility to do a wellness check for Resident #6. -The 2nd PCA and she walked with the officers to Resident #6's room and the resident was "out of it" and unable to answer the officers' questions. -The officer immediately called EMS to come to the facility to check Resident #6. -When the officers informed the MA that EMS had been called, she became argumentative with them. -The paramedics arrived at the facility a few minutes later, checked the resident and informed staff he had a low-grade temperature and his blood sugar was high and he was likely septic. -The resident was transported to the local ER by EMS and was admitted to the hospital. She drove separately to the ER with the resident. -The resident was intubated and transferred to the ICU. Attempted interview with the 2nd PCA on 04/15/21, but the PCA was not available for interview. Attempted interview with the MA on 04/16/21, but the MA was not available for a 2nd interview.	D 273		

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Telephone interview with Resident #6's family member on 04/13/21 at 9:30am revealed:
-The facility did not call her or any other family to report the resident had fallen or that the resident was admitted to the hospital.
-She received a call from the hospital on 04/03/21 and was told the resident was septic and was transferred to the ICU.

Interview with the Resident Care Coordinator on 04/16/21 at 5:00pm revealed:
-She was aware a PCA (2nd shift) had reported to the 2nd shift MA that Resident #6 was not "acting right" but his vital signs were okay except for a low-grade fever.
-The MA reported to her that the resident's abdomen was hard, but she had called the resident's PCP and received orders to administer Tylenol for fever and Dulcolax for constipation.
-She received a report from another staff that Resident #6 had become sicker on 04/03/21 and was not transported to the ER until local law enforcement officers arrived at the facility and called EMS.
-She was not at work on 04/03/21, but when she returned to work on 04/05/21, she was only informed that Resident #6 was found sitting on the floor, but later was informed the resident had become sick.
-If a resident had acute status changes, she expected the MAs to assess the resident, call the PCP to report the changes and call EMS if necessary.

Interview with the Administrator on 04/16/21 at 5:25pm revealed:
-She was not aware Resident #6 had a status change and had a low-grade fever for 2 days.
-She was not informed the resident had fallen on 04/02/21 and 04/03/21.

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-The 2nd shift MA had informed her the resident was constipated on 04/03/21 but did not inform her the resident's abdomen was tight and hard.
-If a resident had an acute status change or had fallen, she expected the MAs to check the resident's vital signs, check for injuries and call the resident PCP immediately to report the fall.
-If the resident had a fever that did not resolve, breathing problems, increased weakness, a fall which was unwitnessed or if there was a suspected head injury or injury of any kind, staff should call EMS and the resident transported to the local ER for evaluation.
-When she was at the facility, she walked up and down the halls and checked on the residents, but apparently when she was not at the facility, staff was not providing resident care as the were trained and per facility's policy.

2. Review of Resident #12's current FL-2 dated 04/18/20 revealed:
-Diagnoses included dementia, unresponsiveness, syncope, Parkinson's disease, cardiomyopathy, depression, and prone to falls.
-The resident was intermittently disoriented.
-The resident was non ambulatory and used a wheelchair.

Review of Resident #12's current assessment and care plan dated 04/22/20 revealed:
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident was totally dependent on staff for bathing, ambulation, dressing, grooming and transferring.

Review of Resident #12's physician orders revealed:
-There was a standard order for medications and treatments dated 04/22/20.

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-There was an order for minor cuts, scrapes and burns to clean the affected areas with mild soap and water, apply Neosporin ointment (Neosporin is a topical antibiotic ointment for minor cuts and abrasions) to the affected area, may cover with sterile dressing or band aide three times a day until healed and notify the PCP if the area was not better in one week, or if rash, redness (signs of infection) swelling or fever was present.
-There were no additional orders wound care orders for the resident.

Review of Resident #12's progress notes documented by a medication aide (MA) on 02/09/21 revealed:
-The resident had a sore on his right hip.
-The resident's PCP was contacted and had an appointment for 02/11/21 at 2:00pm.

Telephone interview with the Clinical Manager with Resident #12's primary care provider (PCP) on 03/15/21 at 3:14pm revealed:
-The last appointment Resident #12 was seen was 01/27/21 and at that time there was dictation the resident was eating and sleeping well, and the resident had no pressure wounds.
-There was no documentation in the resident's record of any type of wound.

Confidential interview with a former staff revealed:
-Approximately seven to nine days before Resident #12 passed away, the resident had a decreased appetite, lost weight and his bones began to protrude at which time the resident developed a small opened area on his hip that was "barely open".
-A few days prior to Resident #12's death, the same area on the resident's hip worsened progressing to the size of a "fist" with a dry, black

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colored wound bed.
-The area on Resident #12's hip was not draining and did not have an odor.
-The Administrator was notified on the same day the resident's wound bed was observed to have worsened.
-The Administrator looked at Resident #12's hip wound, cleaned the area and applied a dry dressing.
-The Administrator told the staff Resident #12 did not need to be sent out for evaluation.
-The staff was concerned because residents were not sent out for evaluation when there was a change in status like they should have been.
-Resident #12's PCP was not contacted and notified concerning the worsening wound on the resident's hip.

Interview with a personal care aide (PCA) on 04/15/21 3:48pm revealed:
-Resident #12 required assistance with bathing, dressing, grooming and transfers.
-A week or so prior to Resident #12 passing away, she noticed the resident had a red spot on his hip and she reported it to a medication aide (MA).
-She remembered the next time she saw the area on Resident #12's hip it looked "horrible" and was draining a thick yellow drainage and was purple in color.
-She estimated the discolored area to be the size of a golf ball.
-The MA would have been responsible for providing any needed dressing changes to Resident #12's wound.

Interview with a second PCA on 04/15/21 at 9:35pm revealed:
-Resident #12 had a sore on his hip that was pinkish red and not opened.

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-He was not sure of the specific date, however thought it was February 2021 when the area on Resident #12's hip occurred.
-He was told informed about the pinkish red area on Resident #12's hip from other staff at shift change.
-The MAs started applying a dressing to the area on Resident #12's hip later so he was unsure what the red area looked like.
-He was not sure how the area on Resident #12's hip occurred.

Interview with a MA on 04/15/21 at 3:34pm revealed:
-Resident #12 was dependent on staff for bathing, dressing, and transferring.
-Resident #12 was able to propel himself in a wheelchair once he was transferred by staff.
-Resident #12 did not have any decrease in is appetite nor had he lost any weight prior to passing away that he recalled.
-He was aware Resident #12 had one wound on his hip because staff were providing treatment for the wound with dressing changes.
-When he first started "treating" Resident #12's wound the area was not opened and was only a big red spot.
-He could not exactly remember what type of wound care was provided but thought an ointment was applied to Resident #12's wound bed and a dry dressing.
-Resident #12 had a standing order as needed for wound care.
-The MA would have been responsible to document wound care provided on the residents' in the residents' progress notes.
-Resident #12 had an appointment scheduled to evaluate the wound on his hip.
-He was not sure and could not provide any additional information regarding Resident #12's

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wound or if the resident went to the appointment.

Interview with a second MA on 04/15/21 at 9:13pm revealed:
-She worked second and third shift.
-Resident #12 was total care expect for eating, however, occasionally would require feeding assistance.
-She was not aware of any wound on the resident's hips other than a bruise.
-She was not sure how the bruise on Resident #12's hip occurred.
-She had not seen a dressing on Resident #12's hip because first shift completed treatments and the PCAs provided incontinent care.
-MAs were responsible to contact the PCP when residents had a change in their status.

Interview with a third MA on 04/16/21 at 10:49am revealed;
-He had worked at the facility off and on since 2014, however started working full time in September 2020.
-He only worked first shift.
-When Resident #12 was first admitted, the resident was walking with a cane however later started to use a wheelchair for ambulation.
-Resident #12 required total care from staff.
-Resident #12 had a "pressure sore" on his hip.
-When Resident #12's hip wound first began, the wound was red and progressed over time.
-Resident #12's hip wound was red and weeping a yellow colored drainage.
-Resident #12's wound did not have any odor.
-Resident #12's wound care for his hip wound was a wet to dry dressing using normal saline.
-There should have been an order for the wound care provided in Resident #12's record.
-The MAs were responsible to contact the PCP when a resident had skin changes and document

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in the progress notes in the residents' record.
-The MAs were not required to fax an order to the PCP when an order was given because the PCP usually faxed the order to the facility.

Interview with the Secretary on 04/16/21 at 4:14pm revealed:
-She had worked at the facility for 25 years.
-Her job titles included supervisor and as needed worked as a PCA.
-She did not pass medications as a MA.
-The facility did not complete any type of skin assessment sheets for the residents.
-She never saw a wound on Resident #12's hip.

Interview with the Resident Care Coordinator on 04/16/21 at 5:24pm revealed:
-She was not aware Resident #12 had a wound on his hip.
-She would have expected the MA to notify the Resident #12's PCP or send the resident to the emergency room for evaluation immediately if a resident had a wound that was opened and draining.
-Staff would have been responsible to document when a resident had a change in skin status.
-The only type of wound dressing staff could apply without an order would have been a dry dressing to protect the area.

Interview with the Administrator on 04/16/21 at 4:50pm revealed:
-She was aware Resident #12 had a wound on his hip because a staff had reported the area to her.
-She observed Resident #12's hip wound and at that time the area was very small (approximately 1 cm or less) with redness and a "black spot" in the middle of the wound bed.
-She was not sure what the black spot was.

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-Resident #12's hip wound did not have any drainage or odor.
-She told "somebody" (a staff) to notify Resident #12's PCP regarding the wound for an appointment so the resident's wound could be evaluated.
-She cleaned the wound the day she observed Resident #12's hip wound with wound cleanser containing normal saline and applied a dry dressing.
-The dressing was applied to the area on Resident #12's hip to protect the area only from friction that could possibly cause additional injury or breakdown.
-She was not aware Resident #12's wound had developed any drainage.
-She would have expected the MA to notify Resident #12's PCP if the wound had developed a yellow drainage.
-Resident #12 did not have an order for wound care and a normal saline wet to dry dressing or any type of ointment to the wound would require a signed order from the resident's PCP.
-She would have concerns of possible infection if Resident #12's wound had yellow drainage.

Telephone interview with Resident #12's PCP on 04/15/21 at 5:00pm revealed:
-The resident was emaciated and wheelchair bound.
-When he saw the resident on visits, the resident was gradually getting worse and going "downhill".
-He was not aware Resident #12 had any open wounds and had not provided staff with any wound care orders.
-Staff were responsible to write verbal orders and fax to him so that he could sign and fax the order back to the facility by the next day of possible.
-There were different wound stages and typically wounds categorized at a stage 1 -2 were

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common, however wounds reaching a stage 3 or 4 could cause infection and sepsis.
-It was "definite" staff should have notified him if Resident #12's wound had thick yellow drainage.
-Staff had been advised to contact him with any concerns and aware he was available 24 hours a day.

3. Review of Resident #5's current FL-2 dated 02/25/21 revealed:
-Resident was admitted to the facility on 03/12/21.
-Diagnoses included alcohol abuse, History of stroke, idiopathic, epilepsy, pneumonia due to infectious organism, progressive neuropathy and spastic hemiplegia.
-Resident #5 was non-ambulatory.
-Resident #5 was constant disorientated.
-Resident #5 did not have any information on inappropriate behaviors.
-Resident #5 did not have an order for Tylenol.

Review of Resident #5's Care Plan dated 02/25/21 revealed:
-Resident #5 required total assistance with toileting, ambulation, eating, bathing, dressing, grooming and transfers.
-Resident #5 had a history of verbal aggression.
-Resident #5 required monitoring for skin breakdowns, seizures, and falls.

Interview with Resident #5 on 04/13/21 at 2:28pm revealed:
-On 04/09/21 Resident #5 was dropped on the floor by a personal care aide (PCA).
-Resident #5 was unsure of the exact time this event occurred but stated it was in the evening.
-The PCA attempted to transfer Resident #5 from his wheelchair to the bed and dropped Resident #5 on the floor.
-The PCA attempted to assist Resident #5 up

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from the floor by pulling up on Resident #5's left arm and shoulder.
-Resident #5 sustained soreness in the left upper arm and shoulder as a result of the PCA pulling and picking him up by his left arm.
-Resident #5 reported the incident to the supervisor/medication aide (MA).
-Resident #5 was administered two Tylenol 325mg tablets later during the shift for pain and discomfort.
-Resident #5 had been administered two Tylenol 325mg for pain every 4 - 6 hours every day since that incident occurred.

Observation of Resident #5 on 01/13/21 at 2:28pm revealed:
-Resident #5 left foot and ankle was bigger in appearance then his right foot and ankle.
-Resident #5 could not lift his left arm up all the way without complaining of pain and discomfort.

Interview with the named PCA on 04/13/21 at 4:29pm revealed:
-She did not recall anyone falling or being dropped on the floor, "that never happened."
-Facility residents "do whatever they want" and the facility staff "take care of them."
-She did not have assistance with transferring Resident #5.

Interview with Supervisor/MA on 04/16/21 at 10:50am revealed:
-Supervisor/MA administered Resident #5 two Tylenol 325mg every 4-6 hours or whenever he requested it.
-Supervisor/MA administered the Tylenol to Resident #5 because he complained of pain in his left shoulder and arm but did not know where it came from.
-Supervisor/MA did not inquire about the pain in

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Resident #5's left arm and shoulder.
-Supervisor/MA did not document anywhere on Resident #5's medication administration record (MAR) that the Tylenol had been administered.
-There was no order on Resident #5's MAR for Tylenol.
-Resident #5 had a standing order for Tylenol but there was no place to document it was given.
-Supervisor/MA was not made aware of the PCA dropping Resident #5.
-Supervisor/MA could not recall how many Tylenol had been administered to Resident #5 the date of the alleged incident.
-Supervisor/MA had administered two Tylenol 325mg tablets to Resident #5 since 04/09/21 but could not show documentation where the medication had been administered.

Interview with Resident #5's Primary Care Provider (PCP) on 04/15/21 at 11:39am revealed:
-There were no reports made regarding an incident with Resident #5 on 04/09/21.
-When the facility calls the PCP to make a report it is always documented.

4. Review of Resident #1's current FL-2 dated revealed 11/24/20:
-Diagnoses included hypertension, dementia with psychosis, incontinence, chronic debility, and schizophrenia.
-Her orientation and functional limitations were documented as "not applicable."
-Her inappropriate behavior and neurological sections were blank.
-She required personal care assistance with bathing, feeding, and dressing.
-She required total care.
-She was semi-ambulatory with Geri-chair.
-She was incontinent of bladder and bowel.

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Review of Resident #1's primary care provider (PCP)'s order dated 11/11/20 revealed:
-There was order for a mammogram, an eye exam, and a stool-DNA screening test for detecting colon cancer.

Review of Resident #1's medical record revealed there was no documentation of mammogram results, an eye exam, or a stool DNA test results from the PCP's order dated 11/11/20.

Interview with the Administrator on 04/14/21 at 12:37pm revealed:
-Resident's appointments were given to the Resident Care Coordinator (RCC) to schedule.
-The RCC was responsible to contact the physician specialty office to schedule the resident's appointment.
-The RCC worked Monday, Wednesday, and Friday from 2:00pm to 10:00pm.
-A medication aide was being trained to process resident appointment and orders on the days the RCC was not at the facility.
-The facility's secretary and the Administrator would check if resident orders were processed by the RCC within a couple of days.

Interview with the RCC on 04/16/21 at 4:33pm revealed:
-For new resident's orders, the medication aide (MA) who was working during the receipt of new order(s), the RCC, and the Administrator were responsible to process the new orders.
-New orders were expected to be processed within 24 to 48 hours.
-She completed resident chart audits if the resident had a significant change, for example, if the resident could no longer walk, after a resident's hospitalization, after a resident's annual

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exam was completed, or if she received a new resident order.
-After a resident hospitalization, "you got to start all over again."
-The resident's old information was "purged" by the facility.
-Resident #1's order for a mammogram dated 11/11/20 had been scheduled for 04/2021.
-Resident #1's mammogram was not scheduled until "this month" due to COVID-19 restrictions, they were not allowing patients to come into the office.
-Resident #1's order for an eye exam dated 11/11/20 had been scheduled for 05/27/21.
-Resident #1's eye exam was not scheduled until "this month" due to COVID-19 restrictions, they were not allowing patients to come into the office.
-She was not sure Resident #1's stool-DNA screening test for detecting colon cancer was completed.
-It may have not been completed to due to a "limited number" of workers to process the stool-DNA screening test for detecting colon.

Interview with the Administrator on 04/16/21 at 5:13pm revealed:
-Resident #1's order for a mammogram dated 11/11/20 had been scheduled for 04/2021.
-Resident #1's mammogram was not scheduled until "this month" due to COVID-19 restrictions, they were not allowing patients to come into the office.
-Resident #1's order for an eye exam dated 11/11/20 had been scheduled for 05/27/21.
-Resident #1's eye exam was not scheduled until "this month" due to COVID-19 restrictions, they were not allowing patients to come into the office.
-Resident #1's stool-DNA screening test for detecting colon cancer had not been completed by the facility.

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-It may have not been completed by the facility because Resident #1's was not willing to comply with the steps on how the stool was collected.

Attempted telephone interviews with Resident #1's primary care provider on 04/16/21 at 10:00am and 10:46am were unsuccessful.

Resident #1's mammogram and optometrist provider were requested on 04/14/21 and 04/15/21 and was not provided prior to the survey exit on 04/16/21.

5. Review of Resident #3's current FL-2 dated 07/09/20 revealed:
-Diagnoses included Alzheimer's dementia, severe sepsis (resolved), coronary obstructive pulmonary disease, abnormal weight loss, diabetes type 2, hypertension, coronary artery disease and hypercholesteremia.
-There was no documentation for the resident's orientation status.
-The resident was ambulatory and required assistance with bathing and dressing.
-The resident was incontinent of bowel and bladder.

Review of Resident #3's current assessment and care plan dated 07/09/20 revealed:
-The resident was always disoriented with significant loss, requiring direction.
-The resident was totally dependent on staff for toileting, bathing, dressing grooming and transferring.
-The resident required limited assistance from staff with bathing and dressing.

Review of Resident #3's primary care provider (PCP) order dated 11/04/20 revealed a Cologuard had been ordered, follow instructions and return

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within 2 weeks. (A Cologuard is a stool-DNA screening test to detect colorectal cancer and precancer).

Review of Resident #3's progress notes documented by the facility's Secretary/personal care aide (PCA) on 11/11/20 revealed the resident had new orders including a Cologuard.

Additional review of Resident #3's progress notes revealed there was no documentation the resident's Cologuard test had been completed as ordered.

Interview with the Resident Care Coordinator on 04/16/21 at 5:24pm revealed:
-She was not sure if Resident #3's Cologuard test had been completed as ordered on 11/04/20.
-The results of the Cologuard tests were slow to come back, however, would have expected Resident #3's results back and finalized from November 2020.
-The Cologuard kits were available and at the facility.
-The medication aides (MAs) would have been responsible to collect the specimen sample, package the sample by following the labeled instructions, then contact the provider "1 800" number for the specimen to be picked up from the facility.
-There should have been documentation in the residents' record if staff collected or attempted to collect Resident #3's specimen for the Cologuard test.
-The results of the Cologuard test would have been sent to the residents' PCP.
-Every Monday, she reviewed the residents' medical appointment book which indicated which residents were seen by the PCP, then reviewed if any new resident orders were written during the

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visit and posted sticky notes in her office until the order was completed.
-She thought the Cologuard test ordered for Resident #3 was overlooked and not completed as ordered.

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

Attempted telephone interview with Resident #3's Power of Attorney (POA) was unsuccessful on 04/16/21.

Interview with the Administrator on 04/16/21 at 6:05pm revealed she expected all resident orders to be implemented as ordered.

The facility failed to ensure the acute and routine health care needs were met for 5 of 7 sampled residents including not reporting/responding to acute emergency medical changes for Resident #6 who displayed increased weakness, decreased alertness decreased oxygen saturation, respiratory distress, increased temperature, abdominal distension and falls ongoing for 2 days before EMS was called by local law enforcement officers and the resident was hospitalized/ intubated, placed on a ventilator and treated for septic shock and skin changes to Resident # 12's hip wound that progressed from a red area to an large open wound with thick yellowish drainage and covered with black tissue to the PCP. The facility's failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 04/14/21.

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D 273	Continued From page 81 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 27, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement orders for 2 of 6 sampled residents (#1 and #2) who had a history of acute cerebrovascular accident (CVA) and atrial fibrillation and had blood pressure and pulse ordered to be monitored twice a day (#2) and who required total care with her activities of daily living had an order for an eggcrate topper for her Geri-chair and mattress (#1). The findings are: 1.Review of Resident #2's current FL-2 dated	D 276		

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01/20/21 revealed:
-Diagnoses included acute cerebrovascular accident (CVA), atrial fibrillation, diabetes mellitus type 2 and major depressive disorder.
-The resident was intermittently disoriented.
-The resident was non-ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident required total care with toileting, ambulation, bathing, dressing, grooming and transfer.
-The resident required limited assistance with eating.
-The section for orders/treatments was blank.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 01/20/21 and was signed but not dated.

Review of Resident #2's current resident care plan signed and dated 02/15/21 revealed:
-The resident was non-ambulatory with a wheelchair and required staff assistance.
-The resident was incontinent of bowel and bladder.
-The resident required limited staff assistance with feeding for all meals and snacks.
-The resident required total assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Review of Resident #2's subsequent physician orders dated 02/15/21 revealed there was an order from the Primary Care Provider (PCP) for blood pressure (BP) and pulse monitor twice a day.

Resident #2's vital signs monitoring sheet was requested on 04/14/21 and was not provided by the time of exit.

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D 276	Continued From page 83 Interview with a medication aide (MA) on 04/15/21 at 10:13am revealed: -The MAs were responsible to process the physician orders when they were received. -The physician orders were faxed into the pharmacy. -The pharmacy would enter the orders on the eMAR and the MAs would have to approve it for the order to show up on the computer. -The MAs were responsible to obtain residents vital signs. -She was not sure what happened that this order was not processed and started. Interview with the Administrator on 04/16/21 at 11:10am revealed: -The MAs were responsible to check the physician orders and fax them to the pharmacy. -New orders were put in to the eMAR by the pharmacy. -The MA would have to approve the new order for it to show up on the computer. -She expected this to be done as soon as the order was received. -The Resident Care Coordinator (RCC) was responsible following up with new orders for the residents. -She was not sure how the blood pressure and pulse order was not completed. Attempted interview with the PCP on 04/15/21 at 4:11pm was unsuccessful. 2. Review of Resident #1's current FL-2 dated revealed 11/24/20: -Diagnoses included hypertension, dementia with psychosis, incontinence, chronic debility, and schizophrenia. -Her orientation and functional limitations were	D 276		

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documented as "not applicable."
-Her inappropriate behavior and neurological sections were blank.
-She required personal care assistance with bathing, feeding, and dressing.
-She required total care.
-She was semi-ambulatory with Geri-chair.
-She was incontinent of bladder and bowel.

Review of Resident #1's current care plan dated revealed 11/24/20:
-She required limited assistance with eating.
-She required extensive assistance with ambulation/locomotion and transferring.
-She was totally dependent for assistance with toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #1's primary care provider's order dated 11/06/20 revealed:
-There was an order for an egg crate topper for her bed.
-There was an order for an egg crate topper for her chair.

Observation of Resident #1's room on 04/13/21 at 8:13am revealed:
-Resident #1 was in a Geri- chair.
-Her knees were flexed in an upward position.
-Her feet were crossed.
-Her head was resting on the side cushion of the Geri-chair.
-There was a bed sized pillow to the right side of Resident #1's body.
-There was no egg crate topper observed in Resident #1's Geri-chair or Resident #1's bed.

Observation of Resident #1's room on 04/13/21 at 8:13am revealed:
-There was no egg crate topper observed in

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D 276	Continued From page 85 Resident #1's bed. Observation of the facility's dining room on 04/13/21 at 11:41am revealed: -Resident #1 was in a Geri- chair. -There was no egg crate topper observed in Resident #1's Geri-chair. Observation of Resident #1's room on 04/13/21 at 2:51pm revealed: -Resident #1 was laying on her side in her bed. -There was no egg crate topper observed in Resident #1's Geri-chair or bed. Observation of Resident #1's room on 04/15/21 at 9:12am revealed: -Resident #1 was in a Geri- chair. -There was no egg crate topper observed in Resident #1's Geri-chair. Interview with the Administrator on 04/16/21 at 5:13pm revealed: -Resident #1's full size egg crate was outside on the clothes' line. -She knew the egg crate was laundered daily due to Resident #1 being incontinent of bladder and bowel. -She was not sure how long the egg crate was out on the facility's clothes' line. Observation of the clothes' line in the facility's backyard at 5:45pm revealed there was a full-size egg crate hanging on the clothes' line. Interview with the Administrator on 04/16/21 at 5:45pm revealed: -She was not sure how long the egg crate was out on the facility's clothes' line. -She was not sure why there was not an egg crate on Resident #1's Geri-chair or bed from	D 276		

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D 276	Continued From page 86 04/13/21 to 04/16/21. Attempted telephone interviews with Resident #13's primary care provider on 04/16/21 at 10:00am and 10:46am were unsuccessful.	D 276		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the facility had activities for residents to participate. The findings are: Review of the April 2021 activities calendar in the hallway next to the medication room revealed: -There were fourteen hours of activities for each week of April 2021. -On 04/13/21 from 10:30am to 11:30am, an exercise session was listed. -On 04/14/21 from 2:00 pm to 4:00 pm, checkers activity was listed. -On 04/15/21 from 2:00pm to 5:00pm, an ice cream party was listed.	D 315		

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D 315	Continued From page 87 Observations on 04/13/21 from 10:30am to 11:30am, revealed there was not an exercise session being conducted. Observations on 04/14/21 from 2:00 pm to 4:00 pm, revealed there were no checkers activity being conducted. Observations on 04/15/21 from 2:00pm to 5:00pm, revealed there was not an ice cream party being conducted. Observation of the facility on 04/13/21, 04/14/21, 04/15/21, and 04/16/21 throughout the days revealed: -There was an activities calendar posted on the wall of the facility in the main hallway. -Residents sat along the halls, in their bedrooms or in the dayroom watching television much of the day. -There were residents observed outside of the facility out the back door in the "smoking" area. -There were residents observed walking out of the facility stating they were going to the store. -No residents were observed signing out of the facility when they left to go to the store. -No activities were observed being conducted. -There was no observation of staff offering group or individual activities to the residents. Interview with a resident on 04/12/21 at 6:32am revealed: -There had been no activities for the residents in months. -The Activity Director (AD) was out on leave. Interview with a second resident on 04/13/21 at 2:44pm revealed: -There had not been any activities offered to residents in over a year.	D 315		

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-Resident's request for games, such as games boards and playing cards had been unsuccessful.
-There was not a current Activities Director (AD) on staff.
-Before the COVID-19 pandemic, the facility had hotdog cookouts on the weekends for the residents.
-"There was nothing to do around here but smoke cigarettes."

Interview with a third resident on 04/16/21 at 4:17pm revealed:
-He did not know when the last time the residents played this game, "it's been a while".
-He did not remember when they had any activities.
-It was the same stuff on the board, but we do not do those.
-There was no resident council meeting that he knew about.

Interview with a fourth resident on 04/13/21 at 2:28pm revealed:
-There were no activities offered to residents at the facility.
-The facility does not currently have an "activity person."

Interview with a housekeeping staff on 04/16/21 at 10:21am revealed he had not seen any activities taking place at the facility since he was hired 4 weeks ago.

Interview with a personal care aide on 04/16/21 at 10:39am revealed there had not been any activities at the facility since the COVID-19 pandemic started.

Interview with the Resident Care Coordinator on 04/16/21 at 3:55pm revealed:

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D 315	Continued From page 89 -The facility had just hired someone to fill in for the activities director while she was out. -All the activities supplies were kept in the mobile home out back of the facility on property grounds. -The mobile home was used only for storage of supplies and decorations. Observation of the activities supplies on 04/16/21 at 4:00pm revealed: -There was one checkers game which allowed 2 players (combination game of tic-tac-toe and chess) noted in the mobile home storage area. -There were 2 dice games which allowed multiple players. -There were 2 connection board games which allowed 2 players per game. -There were 2 tic-tac-toe games which allowed 2 players per game. -There was 1 board game which allowed up to 4 players where a die was "popped', and pieces moved around the board. -There was 1 board game which used dice to move around the board buying and trading properties which would allow numerous players. -No other games or supplies for other games were observed. -There were 15 video home system (VHS) tapes observed on the shelving unit that held activity supplies. Observation on 04/16/21 at 4:27pm revealed: -There were 10 residents seated in the dining room with game cards on the tables. -There was a staff member calling out the letters/numbers for the game. -Residents used pennies to "mark" their game cards. -There were 2 staff members present to assist residents as needed.	D 315		

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D 315	Continued From page 90 Interview with the Administrator on 04/16/21 at 5:10pm revealed: -The facility had an Activities Director (AD) who was on leave. -The AD had gone out on leave during the COVID pandemic when group activities were not being allowed. -The facility had hired an activity assistant to fill in while the AD was out. -In the event the AD was unable to return to work, the AD assistant would attend the required training to become the new AD. -She was not aware the activities supplies were limited. -She would purchase more supplies like more games and movies for the residents. -The residents liked to play the game (Bingo). -The residents liked to win money (25 cents per win). -The residents kept the money, or they spent it in the office store for drinks or snacks.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, observations, and record reviews, the facility failed to ensure residents were free from physical and verbal abuse as evidenced by a resident being physically and verbally abused by a staff member (#5).	D 338		

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D 338	Continued From page 91 The findings are: Review of Resident #5's current FL-2 dated 02/25/21 revealed: -Resident #5 was admitted to the facility on 03/12/21. -Diagnoses included alcohol abuse, history of stroke, idiopathic, epilepsy, pneumonia due to infectious organism, progressive neuropathy and spastic hemiplegia. -Resident #5 was non-ambulatory. -Resident #5 was constant disorientated. -Resident #5 did not have any information on inappropriate behaviors. Review of Resident #5's Care Plan dated 02/25/21 revealed that Resident #5 required total assistance with toileting, ambulation, eating, bathing, dressing, grooming and transfers. Interview with Resident #5 on 04/13/21 at 2:28pm revealed: -On 04/09/21 Resident #5 was dropped on the floor by a personal care aide (PCA). -Resident #5 was unsure of the exact time this event occurred but stated it was in the evening. -The PCA became agitated and kicked Resident #5 on the right foot near his ankle. -The PCA yelled at Resident #5 calling Resident #5 an explicit name and blamed Resident #5 for falling on the floor. -Resident #5 reported the incident to the supervisor/medication aide (MA). Interview with the PCA on 04/13/21 at 4:29pm revealed she did not recall anyone falling or being dropped on the floor, "that never happened." Telephone interview with Resident #5's family member on 04/14/21 at 3:20pm revealed:	D 338		

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D 338	Continued From page 92 -Resident #5 called his family member and alerted her of being dropped on the floor by Staff A on 04/09/21. -Resident #5 informed his family member that after being dropped, the staff hollered at him, kicked him and called him an explicit name. -The family member instructed Resident #5 to "try to get along" with everyone because she could not afford to move him to the state that she lived in. -The family member instructed Resident #5 to "forget about it, let it go" and not make anyone "mad." -The family member stated that she is working hard to move Resident #5 out of his current placement due to the concerns regarding staff. Interview with Resident #5's primary care provider (PCP) at 11:39 on 04/15/21 revealed: -There were no reports made regarding an incident with Resident #5 on 04/09/21. -When the facility calls the PCP to make a report it is always documented. _____ The facility failed to ensure Resident #5 was free from physical and/or verbal abuse by Staff B as evidenced by being kicked, yelled at and called an explicit name. This failure resulted in substantial risk for physical harm and neglect constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/22/21 for this violation. THE CORRECTIVE DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 27, 2021.	D 338		

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D 367	Continued From page 93	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 3 of 6 sampled residents (#2, #5, #6) for a narcotic used for anxiety (#2), for a pain medication (#5) and for medications administered as needed (prn) (#6). The findings are: Review of Resident #2's current FL-2 dated	D 367		

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01/20/21 revealed:
-Diagnoses included acute cerebrovascular accident (CVA), atrial fibrillation, diabetes mellitus type 2 and major depressive disorder.
-The resident was intermittently disoriented.
-The resident was non-ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident required total care with toileting, ambulation, bathing, dressing, grooming and transfer.
-The resident required limited assistance with eating.
-The section for orders/treatments was blank.

Review of Resident #2's medication orders dated 01/20/21 revealed an order for Alprazolam (a medication used to treat agitation or anxiety) 0.25 mg with instructions to take 1 tablet twice a day as needed (PRN) for agitation or anxiety up to 15 days for anxiety.

Review of Resident #2's progress notes dated 01/26/21 revealed there was an order for Alprazolam 0.25 mg by mouth (po) 2 times daily one-time order.

Review of Resident #2's progress notes dated 02/05/21 revealed there was an order for Alprazolam 0.25 mg po 2 times daily PRN for anxiety for up to 5 days.

Review of Resident #2's April 2021 electronic medication administration record (eMAR) revealed:
-There was no entry for Alprazolam.
-There was no documentation of Alprazolam as being administered in April 2021.

Review of Resident #2's Narcotic Count Sheet

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(NCS) on 04/12/21 revealed there were 13 Alprazolam 0.25 mg tablets on hand and verified during the medication pass observation.

Review of the subsequent physician orders dated 04/12/21 revealed:
-There was an order to discontinue the Alprazolam 0.25 mg PRN.
-There was an order to start clonazepam 0.5 mg 1 tablet in the morning.

Review of Resident #2's NCS on 04/15/21 at 11:03am revealed:
-There were 9 Alprazolam 0.25 mg tablets on hand and verified during the medications on hand observation.
-There was an entry on 04/12/21 at 9:00pm as 1 tablet of Alprazolam 0.25 mg being administered.
-There was an entry on 04/15/21 at 7:00am as 1 tablet of Alprazolam 0.25 mg being administered.
-There was an entry on 04/16/21 at 8:00am as 1 tablet of Alprazolam 0.25 mg being administered.
-There was an entry for 7 tablets of clonazepam being received on 04/13/21 at 11:00pm.
-There were entries for the administration of clonazepam 0.5mg administered on 04/14/21 7:00am and on 04/15/21 at 8:00am.

Interview with Pharmacist on 04/16/21 at 11:08am revealed:
-Alprazolam 0.25 mg sixty tablets were dispensed on 01/26/21 for Resident #2.
-There were no Alprazolam tablets returned to the pharmacy from the facility for Resident #2 as of the time of the interview.

Interview with a medication aide (MA) on 04/15/21 at 10:13am revealed:
-She had not administered Resident #2's PRN Alprazolam dose since he was admitted.

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-Pharmacy deliveries came in at night usually between second and third shift.
-The MA would sign for the medications and put them on the cart.
-Narcotics required to be signed in on the NCS.
-The change of shift required the oncoming and off going MAs to count the narcotics and sign for the correct count.
-She did not remember having any counts that were not correct.
-If medications had to go back to the pharmacy, the second or third shift MAs took care of them.

Interview with the Administrator on 04/16/21 at 11:10am revealed:
-The MAs were responsible to check the physician orders and fax them to the pharmacy.
-New orders were put in to the eMAR by the pharmacy.
-The MA would have to approve the new order for it to show up on the computer.
-If an order was to discontinue a medication, it works the same way.
-The medication that was discontinued should be pulled off of the medication cart and the form for the return to the pharmacy should be completed.
-She expected this to be done as soon as the order to stop the medication was received.
-She expected the discontinued medication to be returned to the pharmacy within a week from it being discontinued dependent upon the pharmacy's scheduled deliveries and pick-up.
-The Resident Care Coordinator (RCC) was responsible for the medication cart audits and following up with new orders for the residents.
-She would go remove the Alprazolam from the medication cart immediately to prevent further administration from occurring.
-She would call the Primary Care Provider (PCP) to inform him that Resident #2 had received 3

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doses of Alprazolam after it had been discontinued.

Attempted interview with the PCP on 04/15/21 at 4:11pm was unsuccessful.

2. Review of Resident #6's current FL-2 dated 02/25/21 revealed diagnoses included atrial fibrillation, cerebral vascular accident (CVA), schizophrenia, and depression.

Review of medication standing orders dated 02/25/21 for Resident #6 revealed orders for Tylenol 325mg, 2 tablets by mouth every 4 hours as needed for pain and fever and Dulcolax 2 tablets by mouth at bedtime as needed for constipation.

Review of a facility progress note for Resident #6 (3:00pm - 11:00pm shift) dated 04/02/21 revealed:
-The resident was looking pale and staff checked his vital signs and he was running a low-grade temperature.
-The PCP was called, and he instructed the staff to monitor the resident and administer Tylenol for fever.

Review of Resident #6's electronic medication administration record (eMAR) for April 2021 revealed:
-And order for Tylenol 324mg, 2 tablets every 4 hours as needed for pain and fever was not printed on the MAR.
- There was no documentation on the April 2021 MAR that Tylenol was administered on 04/02/21.

Review of a progress note for Resident #6 (3:00pm - 11:00pm shift) dated 04/03/21 revealed:

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-The medication aide (MA) asked the resident if was okay and the resident informed the MA he constipated.
-The MA checked the resident's stomach and it felt hard and the resident's temperature was 99.7 degrees F.
-The MA called the resident's PCP to report the changes and instructions were given to administer Tylenol for fever and administer 2 Dulcolax tablets with a cup of coffee.

Review of Resident #6's eMAR for April 2021 revealed:
-An order for Dulcolax 2 tablets at bedtime as needed for constipation was not printed on the MAR.
- There was no documentation on the April 2021 MAR that Dulcolax was administered on 04/03/21.

Interview with the facility's Pharmacist on 04/15/21 at 11:05am revealed:
-When a facility implemented medication standing orders, staff should fax a signed copy of the standing order sheet and indicate which medication that needed to be added to the eMAR.
-For verbal/telephone orders received by the facility, the orders should be faxed to the pharmacy immediately and the orders would be added to the eMAR.
-The facility did not fax or call the pharmacy regarding implementing any of Resident #6's standing order nor did the facility fax any telephone/verbal medication orders to the pharmacy for Resident #6.

Interview with a MA/supervisor (3:00pm - 11:00pm shift) on 04/13/21 at 3:40pm revealed:
-She worked second shift (3pm - 11pm) was worked on 04/02/21 and 04/03/21.

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D 367	Continued From page 99 -On 04/03/21 when she was making rounds, she asked the resident if he was okay, but the resident did not respond as usual but did complain being constipation. -She checked the resident and his stomach was hard and his temperature was 99.7 degrees F. -She called the resident's PCP who instructed her to administer Dulcolax with a cup of coffee and Tylenol was administered for his fever. -On her next round the resident was feeling better. -She did not remember if she documented administration of the medications on the resident's eMAR. -She did not document the telephone order on an order sheet, nor did she fax a copy of the standing medication orders to the pharmacy. -She would not state the reason she did not fax the orders to the pharmacy or document the telephone orders. Interview with the facility's Resident Care Coordinator on 04/16/21 at 5:00pm revealed: -When staff implemented a standing medication order or receive a telephone/verbal order, the staff should immediately fax the orders to the facility's pharmacy and the orders would be added to the resident's eMAR by the pharmacy. -The MAs should document on the eMAR, the name of the medication, reason it was administered and if effective. Interview with the Administrator on 04/16/21 at 5:25pm revealed: -She expected the MAs or the RCC to fax all telephone verbal medication orders to the pharmacy immediately. -When implementing the standing medication orders, the MAs/RCC should fax the standing orders to the pharmacy.	D 367		

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D 367	Continued From page 100 -The MAs should document all medications administered to the residents at time of administration. 3. Review of Resident #5's current FL-2 dated 02/25/21 revealed: -Resident was admitted to the facility on 03/12/21. -Diagnoses included alcohol abuse, History of stroke, idiopathic, epilepsy, pneumonia due to infectious organism, progressive neuropathy and spastic hemiplegia. -Resident #5 was non-ambulatory. -Resident #5 was constant disorientated. -Resident #5 did not have any information on inappropriate behaviors. -Resident #5 did not have an order for Tylenol. Review of Resident #5's standard orders for medication and treatment revealed: -For minor pain or discomfort/fever up to 101 degrees: Tylenol 325 mg take two by mouth every 4 hours as needed for pain and fever. -Do not exceed 4 doses in a 24-hour period. -Notify MD if redness or swelling was present, pain was not relieved by Tylenol or last for more than days. -Notify MD if cough lasts for more than 7 days, came back , or was accompanied by fever, rash, or persistent headache. Review of Resident #5's April 2021 electronic medication administration record (eMAR) revealed: -There was no entry for Tylenol. -There was no documentation of Tylenol as being administered in April 2021. Interview with Resident #5 on 04/13/21 at 2:28 pm revealed:	D 367		

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D 367	Continued From page 101 -On 04/09/21 Resident #5 was dropped on the floor by the personal care aide (PCA). -Resident #5 was unsure of the exact time this event occurred but stated it was in the evening. -The PCA attempted to transfer Resident #5 from his wheelchair to the bed and dropped Resident #5 on the floor. -Resident #5 was administered two Tylenol 325mg tablets later during the shift for pain and discomfort. -Resident #5 had been administered two Tylenol 325 mg for pain every 4-6 hours every day since that incident occurred. Interview with a medication aide (MA)/Supervisor on 04/16/21 at 10:50 am revealed: -MA/Supervisor administered Resident #5 two Tylenol 325 mg every 4-6 hours or whenever he requested it. -MA/Supervisor did not document anywhere on Resident #5's medication administration record (MAR) that the Tylenol had been administered. -There was no order on Resident #5's MAR for Tylenol. -Resident #5 had a standing order for Tylenol but there was no place to document it was given. -MA/Supervisor could not recall how many Tylenol had been administered to Resident #5 the date of the alleged incident. -MA/Supervisor had administered two Tylenol 325mg tablets to Resident #5 since 04/09/21 but could not show documentation where the medication had been administered. Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 04/14/21 at 2:31pm. _____ Telephone interview with the pharmacist at the facility's contracted pharmacy on 04/14/21 at	D 367		

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D 367	Continued From page 102 2:31pm revealed: -Each resident at the facility had standing orders for over the counter medications. -The orders for a resident's standing medications (Tylenol, Robitussin, Milk of Magnesia, Dulcolax, etc...) did not appear on the resident's medication administration record (MAR). -A resident's standing medications would only appear on the resident's MAR when a request was submitted by the facility. -The request for the documentation of the medication administration of a resident's standing order medication on the MAR could be submitted to the pharmacy by phone or fax. -If a standing order medication was administered to a resident after the pharmacy had closed, the medication aide could add the medication administration to the MAR. -Any medication administered to a resident should be documented on the MAR so each shift was aware of all medications a resident received prior to their shift.	D 367		
D 435	10A NCAC 13F .1202 Disposal Of Resident Records 10A NCAC 13F .1202 Disposal Of Resident Records After a resident has left an adult care home or died, the resident's records shall be filed in the facility for at least one year and then stored for at least two more years.	D 435		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure 1 of 4 sampled resident's records (#10) was maintained in the facility for at least one year after a resident has left an adult care home.

Resident #10's records were requested on 04/14/21.

No records for Resident #10 were provided.

Interview with the Resident Care Coordinator (RCC) on 04/14/21 at 3:50pm revealed:
-Resident #10 had been transported to a urology appointment by a local medical transport company on 03/26/21.
-When residents were transported by this local transport company, they had requested the entire record for the resident.
-While at the urology appointment, something happened and Resident #10 had been transported by the same company to their local emergency room (ER).
-The facility had tried to locate Resident #10's record.
-The urology clinic had the resident's record in storage.

Interview with the staff of the urology clinic on 04/14/21 at 3:56pm revealed that the transport staff who brought Resident #10 to the clinic also transported her to the ER and her facility chart went with her to the ER.

Interview with the Chief Operations Officer for the local medical transport company on 04/14/21 at 4:14pm revealed the medical transport team had taken Resident #10 to her urology appointment on 03/26/21, from there to the local ER, and her

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D 435	Continued From page 104 facility chart was left with the resident at the ER. Interview with the medical records staff of the hospital for the receiving ER on 04/14/21 at 4:22pm revealed: -Resident #10 was admitted to the medical intensive care unit (MICU) on 03/26/21. -Any items belonging to the resident would have been stored when she was discharged. Interview with the MICU charge nurse/supervisor on 04/14/21 at 4:57pm revealed: -Resident #10's facility record was still in the MICU. -He would keep it there until proper release information was provided. Interview with the Administrator on 04/15/21 at 10:27am revealed: -Resident #10 had an appointment with her urologist on 03/26/21. -The local medical transport company required the resident's entire record to accompany them on transport. -She planned to call the admitting hospital again on 04/15/21 since they had previously said they would mail Resident #10's record back to the facility. -She did not remember who she had spoken with at the hospital when she called back in March, but when she called back today (04/15/21), she would let me know who she spoke with then.	D 435		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and	D 438		

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D 438	Continued From page 105 supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to report allegations of verbal and physical abuse by Staff A to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours, failed to investigate, and failed to complete the 5-day follow-up reporting for 1 of 2 sampled residents (#5). The findings are: Review of Resident #5's current FL-2 dated 02/25/21 revealed: -Resident #5 was admitted to the facility on 03/12/21. -Diagnoses included alcohol abuse, history of stroke, idiopathic, epilepsy, pneumonia due to infectious organism, progressive neuropathy and spastic hemiplegia. -Resident #5 was non-ambulatory. -Resident #5 was constant disorientated. -Resident #5 did not have any information on inappropriate behaviors. Interview with Resident #5 on 04/13/21 at 2:28pm revealed: -On 04/09/21 Resident #5 was dropped on the floor by Staff A, a personal care aide (PCA). -Resident #5 was unsure of the exact time this event occurred but stated it was in the evening. -Staff A attempted to transfer Resident #5 from his wheelchair to the bed and dropped Resident #5 on the floor. -Staff A became agitated and kicked Resident #5	D 438		

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D 438	Continued From page 106	D 438		

on the right foot near his ankle.
-Staff A yelled at Resident #5 calling Resident #5 an explicit name and blamed Resident #5 for falling on the floor.
-Staff A attempted to assist Resident #5 up from the floor by pulling up on Resident #5's left arm and shoulder.
-Resident #5 sustained soreness in the left upper arm and shoulder as a result of Staff A pulling and picking him up by his left arm.
-Resident #5 reported the incident to the supervisor/medication aide (MA).

Telephone interview with Resident #5's family member on 04/14/21 at 3:20pm revealed:
-Resident #5 called his family member and alerted her of being dropped on the floor by Staff A on 04/09/21.
-Resident #5 informed his family member that after being dropped, the staff hollered at him, kicked him and called him an explicit name.
-The family member instructed Resident #5 to "try to get along" with everyone because she could not afford to move him to the state that she lived in.
-The family member instructed Resident #5 to "forget about it, let it go" and not make anyone "mad."
-The family member stated that she is working hard to move Resident #5 out of his current placement due to the concerns regarding staff.

Refer to the interview with the Resident Care Coordinator (RCC) on 04/16/21 at 5:24pm

Refer to the interview with the Administrator on 04/16/21 at 1:39pm.

_____

Interview with the Resident Care Coordinator (RCC) on 04/16/21 at 5:24pm revealed:

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D 438	Continued From page 107 -She was aware that a 24 hour and a 5 day working report was required when there was a resident abuse, neglect or exploitation to the North Carolina Health Care Personnel Registry (HCPR) however she thought the allegation had to be substantiated. -Staff were required to report any concerns involving resident abuse, neglect and exploitation to the Administrator immediately. -The Administrator was responsible for completing the HCPR 24 hour and 5 day working reports for the facility. Interview with the Administrator on 04/16/21 at 1:39pm revealed: -She was aware HCPR reports should occur initially within 24 hours followed by a 5-day working report. -She had done several HCPR reports in the past and knew an internal investigation was required. -During the internal investigation, the accused staff would have been sent home and unable to work at the facility. -She would initiate the 24 hour report for Staff A. -She would not have allowed Staff A "in this building" if allegations of abuse involving Resident #5 had been reported to her. -She knew when a staff member was accused of an allegation of resident abuse that staff member should be suspended until the investigation was completed. Refer to Tag D 338 10A NCAC 13F .0909 Resident Rights _____ The facility failed to report allegations of verbal and physical abuse by a staff (Staff A) involving 1 of 1 sampled residents (#5). Staff A dropped Resident #5 on the floor, became agitated and kicked Resident #5 on the right foot near his	D 438		

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D 438	Continued From page 108 ankle calling Resident #5 an explicit name. The facility's failure to report an incident of verbal and physical abuse by Staff A allowed both staff to continue to work in the facility with direct contact to all of the residents and delayed reporting the allegations of abuse to HCPR. The facility's failure placed the residents at risk for continued physical and verbal abuse and substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/22/21 for this violation. THE CORRECTIVE DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 27, 2021.	D 438		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be	D 484		

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D 484	Continued From page 109 documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physical restraints were used according to physician's orders for 1 of 6 residents sampled (#2) including use only after an assessment and care planning process had been completed through a team process, used only with a written order from a physician for side rails and after obtaining a signed consent of the resident and that the restraints were checked every 30 minutes and	D 484		

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released every two hours.

The findings are:

1. Review of Resident #2's current FL-2 dated 01/20/21 revealed:
-Diagnoses included acute cerebrovascular accident (CVA), atrial fibrillation, diabetes mellitus type 2 and major depressive disorder.
-The resident was intermittently disoriented.
-The resident was non-ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident required total care with toileting, ambulation, bathing, dressing, grooming and transfer.
-The resident required limited assistance with eating.
-The section for restraints was blank.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 01/20/21 and was signed but not dated.

Review of Resident #2's current resident care plan signed and dated 02/15/21 revealed:
-The resident was uncooperative and resistant to care.
-The resident was non-ambulatory with a wheelchair requiring staff assistance.
-The resident was incontinent of bowel and bladder.
-The resident required limited staff assistance with feeding for all meals and snacks.
-The resident required total assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Observation of Resident #2's room on 04/13/21 at 9:30am revealed Resident #2 was in his hospital

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bed with the left side of the bed against the wall and a side rail on the upper right side of the bed.

Review of Resident #2's subsequent physician orders dated 02/15/21 revealed there was an order for hospital bed but no order for side rails.

Interview with Resident #2 on 04/13/21 at 9:30am revealed:
-He had a "stroke" and caused his left side to be paralyzed.
-The side rail was to keep him from falling out of the bed.
-He was not able to get out of his bed when the side rail was up.
-He had been in the facility for a while about 4 months.
-He was his responsible party.
-He had "sores on his bottom and heels".
-Home health took care of the bandages for him.

Interview with the Administrator on 04/14/21 at 10:43am revealed:
-Resident #2 was out at the primary care providers (PCPs) office.
-Resident #2 had slid out of his wheelchair last night.
-When PCP was notified, PCP requested to see resident in his office this morning.

Interview with Resident #2's family member on 04/14/21 at 10:08am revealed:
-He had not seen Resident #2 since his admission to the facility.
-The facility would call him if anything happened to Resident #2 like when he fell out of the bed or if he had to go to the emergency room (ER).
-He had not been involved in anything regarding Resident #2's care since Resident #2 was his own responsible party, so he was not aware of

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Resident #2 having bed rails.
-Resident #2 had a stroke in June 2020 and was hospitalized.

Observation of Resident #2 on 04/14/21 at 2:22pm revealed the resident was in his bed with the head of the bed elevated and no side rail present, only the universal crossbar (the brace bar that attaches to the bed frame and holds the side rail) remained.

Review of Resident #2's subsequent physician orders dated 04/12/21 revealed although there was no order for the bedrails that were being used, there was an order to discontinue the bedrails, and may use mattress for safety but there was no signature of the author of the order nor the physician's signature.

Review of Resident #2's subsequent physician orders dated 04/14/21 revealed there was a signed physician order for an egg crate mattress and for fall and injury precautions.

Interview with Resident #2 on 04/14/21 at 2:22pm revealed:
-He had gone to the doctor because he had fallen from his wheelchair last night.
-He did not think he had any injuries from the fall.
-He had been sitting in his wheelchair and went to adjust his position when he started to slip.
-He kept slipping until he was kind of sitting on the footrests of the wheelchair.
-"Then all of a sudden the wheelchair flipped over his head."
-He was not sure of other falls he had in the past.
-He was not sure what had happened to his side rail or who or when it was removed.

The physical restraint assessment and care

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D 484	Continued From page 113 planning process and the signed consent of Resident #2 was requested on 04/15/21 at 12:22pm and was not received by time of exit from the survey. Attempted interview with the PCP on 04/15/21 at 4:11pm was unsuccessful.	D 484		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision according to needs for 3 of 9 sampled residents (#4, #13, #16) including failure to monitor residents that were at an increased risk for elopement (#4, #13, #16). [Refer to Tag 270, 10A 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: 1. Based on observations, interviews, and record reviews the facility failed to ensure an immediate response and intervention by staff for 2 of 7	D914		

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D914	Continued From page 114	D914		

sampled residents (#12 and #6) in accordance with the facility's policies and procedures, which included a resident who had 2 falls with possible head injuries (#6) and a resident (#12) found by staff not breathing and without a pulse requiring cardiopulmonary resuscitation (CPR). [Refer to Tag 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to ensure health care referral and follow-up for 5 of 7 sampled residents (#1, #3, #5, #6, and #12) related to not reporting acute health care changes in a resident who was later hospitalized in the intensive care unit (ICU) related to septic shock and placed on mechanical ventilation (#6); a hip wound was not reported the PCP and progressed to an open draining wound (#12), an order for a stool-DNA screening test (#3, #1), a resident who complained of left upper extremity pain after being dropped by staff (#5), and a resident who had an order for a mammogram and eye exam (#1). [Refer to Tag 273, 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)].

3. Based on record reviews and interviews, the facility failed to report allegations of verbal and physical abuse by Staff A to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours, failed to investigate, and failed to complete the 5-day follow-up reporting for 1 of 2 sampled residents (#5). [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].

4. Based on interviews, observations, and record reviews, the facility failed to ensure residents were free from physical and verbal abuse as evidenced by a resident being physically and

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D914	Continued From page 115 verbally abused by a staff member (#5). [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].	D914		