STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL093012	A. BUILDING: _____ B. WING _____	04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIVOTAL CARE	303 W FRANKLIN STREET WARRENTON, NC 27589

(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
C 000	Initial Comments The Adult Care Licensure Section and Warren County Department of Social Service conducted an annual and follow-up survey from April 14, 2021 to April 16, 2021 with an exit by telephone on April 16, 2021.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors had an alarm that was activated and sounded when the door was opened to alert staff for 1 of 1 residents (#1), who was known to wander into the community unsupervised. The findings are: Observations of the facility on 04/14/21 from 8:30am to 5:45pm revealed there was no alarm sounding device when the front or rear entrance	C 069		

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C 069	Continued From page 1 doors to the facility were opened. Observations of the facility on 04/15/21 8:15am to 8:00pm revealed there was no alarm sounding device when the front or rear entrance doors to the facility were opened. Observations of the facility on 04/15/21 from 6:35pm to 7:09pm revealed: -Resident #1 left the facility and the Supervisor-in-Charge (SIC) searched the yard of the facility for her. -The Administrator came to the facility and was informed by the SIC that Resident #1 had left without permission for the second time that day. -The Administrator left via car to search the area for Resident #1. -Resident #1 returned on her own and reported to the SIC and the Administrator that she had gone to see a neighbor; that was all the information Resident #1 would share. -Resident #1 had candy in her pockets when she returned. Review of Resident #1's current FL-2 dated 03/08/21 revealed: -Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia. -Resident #1 was intermittently disoriented. Review of Resident #1's Care Plan dated 10/08/20 revealed: -She was sometimes disoriented, forgetful and needed reminders. -Resident #1 had wandering behaviors. -Resident #1 had disruptive and socially inappropriate behaviors. -Resident #1 had slurred speech.	C 069		

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Review of Resident #1's primary care physicians (PCP)'s visit note dated 03/18/21 revealed Resident #1 should be supervised when leaving the facility for safety reasons.

Review of staff notes for March 2021 and April 2021 revealed:
-Resident #1 left the facility [unsupervised] one time on 03/03/21, two times on 03/11/21, two times on 03/23/21, one time on 03/26/21 and one time on 03/27/21.
-On 04/05/21 and 04/6/21 Resident #1 left the facility unsupervised.

Telephone interview with the Assistant to the Administrator on 04/16/21 at 12:21pm revealed she did not think door alarms would work for Resident #1 because she would become more agitated and aggressive.

Telephone interview with the Administrator on 04/16/21 at 2:15pm revealed:
-She was concerned about Resident #1's safety when the resident left the facility unsupervised because she ate outside of her diet.
-Resident #1 would go into people's homes she did not know and put herself into situations with people [strangers] in the community that were not safe.
-She was concerned Resident #1 did not recognize situations as being unsafe.
-There was nothing she could do to keep Resident #1 out of the road or from getting into cars with strangers.
-The facility did not have alarms on the doors; an alarm would not matter to Resident #1 because she would leave anyway.
-She had considered a pendent or watch for Resident #1 so she could keep track of her but she thought it would be illegal to track her that

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C 069	Continued From page 3 way. Refer to Tag C243 10A NCAC 13G .0901(b) Pesonal Care and Supervision (Type A2 Violation). The facility failed to ensure the entrance and exit doors were equipped with alarms when Resident #1, who was known by staff to wander, left the facility unsupervised. This failure was detrimental to the safety and welfare to Resident #1 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/21 for this violation CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED MAY 31, 2021.	C 069		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the carpeting in the common hallway and sitting area, an air vent on the corner	C 074		

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C 074	Continued From page 4 of the living room wall, walls in the common hallway, two resident bedrooms and the kitchen, and windows in the dining room and a resident bathroom were kept clean and in good repair. The findings are: Observation of the dining room on 04/14/21 at 8:54am revealed two of the windows had a 1-inch gap where the windows were open and did not close. Observation of the common living room and sitting area on 04/14/21 at 8:50am revealed there was grayish-black dirt and lint on the heating vent in the sitting area. Observation of a common area next to the dining room on 04/14/21 at 8:55am revealed: -There was a row of four armchairs that had carpeting in front of them. -The carpeting in front of each chair had multiple stains that were hard, black and discolored. Observation of the common hallway on 04/14/21 at 8:58am revealed the walls in the hallway were dirty with brown and black splatters and drips that had hardened. Observation of resident bedroom #1 on 04/14/212 at 8:59am revealed: -There were black stains on the bedroom carpet that stiff and had hardened. -There was a bathroom adjacent to the resident bedroom that had a window with a metal frame that was propped open with a 10-inch-tall plastic bottle. -When the plastic bottle was removed, the window slammed down very quickly.	C 074		

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C 074	Continued From page 5 Observation of the dining room on 04/14/21 at 9:07am revealed: -The walls in the dining room were dirty. -Underneath the dining room table, the tile had a tear which was to be about 1.5 inches long. Observation of the shared resident bathroom down the common hallway on 04/14/21 at 9:21am revealed the vinyl flooring had a 5-inch hole in it and there was standing water and mildew in the corner near the sink. Observation of the wall in the kitchen on 04/14/21 at 9:54am revealed: -There was a 2-inch square hole in the wall above a deep freezer. -The wall behind and next to the stove up to the ceiling had yellow-brownish splatters and drips that were dried and hardened. Observation of resident bedroom #4 on 04/14/21 at 10:11am revealed: -There was a quarter-size hole in the wall beside the bed. -The bedroom floor had tears in the tile, in which the bed had been moved over the torn tile. -There were brown stains on the floor and around the walls of the room. Interview with the resident, who resided in resident bedroom #4, on 04/14/21 at 10:05am revealed: -He was told by staff to move his bed down to cover the hole in the tile floor. -His window did not work, and it was hard to open. Observation of resident bedroom #2 on 04/14/21 at 4:08pm revealed: -There was a 2-inch by 1-inch hole in the wall	C 074		

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C 074	Continued From page 6	C 074		

above the headboard.
-There was a doorknob missing off one of the double closet doors.

Interview with the resident who resided in resident bedroom #2 on 04/14/21 at 4:08pm revealed:
-The hole in the wall above her bed had been there since she moved into the facility about a year ago.
-There had been a hole behind the door and that had been repaired a while ago, but she did not know why the hole above her bed was not repaired at the same time.
-She had not shown the hole to anyone; she thought the Administrator was aware of the hole because when she moved in there was nothing in the room and the hole was there.
-The doorknob to the closet was missing when she moved into the bedroom; she did not tell anyone about it because she just used the other door to get into her closet.

Interview with a Supervisor-in-Charge (SIC) on 04/14/21 at 12:00pm revealed:
-She could call and report broken items or maintenance needs to the Administrator but she had not had to report anything to the Administrator since she had been there.
-She had not noticed the carpets, floors, walls or vent.
-She was told a company came in to clean and/or repair those things.

Telephone interview with the facility's landlord on 04/15/21 at 1:38pm revealed:
-No one had spoken to her about replacing the windows.
-She had no plan to replace the windows in the facility.
-She did not know why the windows did not close

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C 074	Continued From page 7	C 074		

or stay up.
-She would look at the windows the next time she was in the facility.
-She did not know about the holes in any of the walls.
-She had holes repaired in the walls in some of the resident bedrooms a few months ago; she was not aware of anymore holes.
-The staff could call her directly to report damage and the Administrator or Business Manager could call her or email to let her know of needed repairs.
-She had not done an inspection since the pandemic began.

Telephone interview with the Administrator on 04/16/21 at 2:33pm revealed:
-She had a cleaning company come in and clean the carpet and the walls in February 2021.
-Some of the stains did not come up when they were cleaned so she thought she was going to have to replace the carpet.
-The air vent was due to be cleaned and repainted on 04/20/21.
-The holes in the linoleum flooring in the dining room were going to be repaired on 04/20/21 by a professional flooring company.
-The holes in the linoleum flooring in the bathroom would have to be addressed with the flooring company on 04/20/21.
-The holes in the linoleum flooring in the resident bedroom #4 would have to be addressed with the landlord because of a special situation with that resident.
-She understood it was still her responsibility to take care of the facility, but she needed to get help from the landlord because she could not afford to take care of everything out of her own pocket.
-She was not aware of the holes in the walls in

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C 074	Continued From page 8 the two resident bedrooms or the kitchen. -She was not aware some of the windows would not stay open and were being propped open by staff or residents with items like bottles. -She was concerned about the residents' safety with a heavy window that would not stay open without propping it open. -Staff could call the Business Manager or the landlord themselves. -She did not look at everything every time she was in the facility. -She and the landlord did not get along because of history between them, and she was not comfortable being in the facility, so she tried to let the Business Manager deal with the landlord. -She did not do inspections when she was at the facility.	C 074		
C 076	10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the chairs in the dining room, in the common living room and sitting area, a dresser in a resident bedroom, and the tablecloth on the dining room table were kept clean and in good repair. The findings are:	C 076		

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C 076	Continued From page 9 Observation of the sitting room during the initial tour on 04/14/21at 8:50am revealed: -There was a rocking chair in the sitting area and the headrest was soiled and stained black. -There was a row of four chairs against a wall and one of the chairbacks was separated from the back supports and resting on the seat of the chair. Observation of resident room #3 on 04/14/21 at 9:02am revealed the right middle drawer was missing from the resident's dresser. Attempted interview with the residents, who resided in resident room #3, on 04/14/21 at 9:02am were unsuccessful. Observation of the dining room on 04/14/21 at 9:07am revealed: -There were two high backed upholstered chairs at the dining room table, the tops and seats of both chairs were discolored and had stains and dark spots on them. -There were three metal framed chairs that had rust on the legs and back supports; the vinyl on the chairs was soiled and sticky. -There was a vinyl tablecloth on the dining room table that had multiple holes ranging in size from one inch in diameter to three inches; the fabric backing of the tablecloth was visible around the edges of the holes and was a yellow and brownish color. -The vinyl tablecloth stuck to the table and could not be removed without the backing separating from the vinyl. Interview with a Supervisor-in-Charge (SIC) on 04/14/21 at 12:00pm revealed: -She could report broken items or maintenance needs to the Administrator, but she had not had	C 076		

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C 076	Continued From page 10 to report anything to the Administrator since she had been there. -She did not report it because "everything was like that" when she started working at the facility. Telephone interview with the facility's landlord on 04/15/21 at 1:38pm revealed: -She was not responsible for replacing broken or worn out furnishings; that was the sole responsibility of the Administrator. -She rented the facility as a furnished building, but the Administrator could throw out furnishings due to normal wear and tear and replace them. Telephone interview with the Administrator on 04/16/21 at 2:33pm revealed: -She knew the tablecloth on the dining room table was not the cleanest tablecloth. -Staff should have removed it and washed it. -She did not know it was a vinyl tablecloth on the table or that it had holes in it. -The upholstered and metal chairs were going to be cleaned on 04/20/21 by a professional cleaning company. -The chair in the sitting area was not broken; the back just "gives" when someone sat in it but it was not broken. -She knew the dresser in the resident bedroom was in "disrepair" and had been that way for months; she needed to speak with the Business Manager about replacing it. -She had been spending money on training the staff and not spending money on the furnishings. -The staff were not reporting these "things" to her. -She did not do inspections when she visited the facility.	C 076		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings	C 078		

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C 078	Continued From page 11 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home 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 homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that one resident bedroom and one resident bathroom were maintained in an uncluttered, clean and orderly manner. The findings are: Observation of resident room #1 on 04/14/21 9:02am revealed: -There were clothes piled on the side of the room, obstructing a clear walking space. -There was an upholstered recliner that had clothes piled on the seat, arm and headrest. -There were shoes scattered in the middle of the floor. -There were used surgical bandages and wrappers on the floor and patches for monitors also on the floor. -There were empty snack bags on the floor. Observation of resident bathroom #1 on 04/14/21 at 8:59am revealed: -There was a private bathroom that was only accessible from the resident's bedroom. -There was a bedside commode placed over the toilet in lieu of a lid.	C 078		

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C 078	Continued From page 12 -There were feces on the floor at the entrance to the bathroom and near the toilet. -There were feces on the toilet seat from the bedside commode, and on the base of the toilet bowl. -There were brownish stains in the bathroom sink drain. -There was toilet tissue and snack food wrappers on the floor. -There was a trashcan that was overflowing and had multiple soiled adult briefs stacked on top. -There was a mug with an unknown liquid and a used bar of soap sitting on the counter of the sink. Interview with the resident, who resided in resident room #1, on 04/15/21 at 12:44pm revealed: -The bathroom adjacent to her room was cleaned once or twice a month. -She did not empty her trash. -She did not put away her clean laundry and neither did the staff; she left it in the chair. -The Administrator had asked her about the missing toilet seat, and she told the Administrator she would like a toilet seat. -She told the Administrator she could not sit right on the bedside commode seat. Interview with the Supervisor-in-Charge (SIC) on 04/14/21 at 9:35am revealed: -The residents were responsible for cleaning their own bathrooms during the day and after they used them. -The residents were responsible for wiping down the shower and the sinks after they used them. -The residents wiped up the floor of the bathroom if it was wet. -The residents cleaned their own toilets; the evening staff sanitized the bathroom.	C 078		

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-The residents brought their trash out of their rooms and the bathrooms to her and she took it out to be picked up.
-She looked at the toilet and their dirty clothes and told them whose turn it was to clean.
-The residents brought her their laundry and she washed and folded it for them and gave it to them to put away.
-All the residents cleaned their own rooms; the residents swept but she ran the vacuum cleaner.
-She dusted the furniture in the residents' rooms.
-The resident, who resided in resident room #1, did not clean her room and bathroom on her own so sometimes she would help the resident clean her room and bathroom.

Interview with a second SIC on 04/15/21 at 6:15pm revealed:
-She did the cleaning in the residents' rooms if it needed to be done.
-The residents would bring her their trash.
-She would wash, fold and put away the residents' clothes if they needed it but washing was done on first shift.
-She swept their bedrooms.
-She did not follow a cleaning schedule she just looked at what needed to be done and did it.
-Resident room #1 and the adjacent bathroom got messy very quickly.
-She had cleaned resident room #1 and the bathroom a couple of days ago and was in the process of cleaning it again that night.

Telephone interview with the Administrator on 04/16/21 at 3:22pm revealed:
-The staff were supposed to clean the bathrooms on each shift.
-Trash was supposed to be emptied twice a day; there was no excuse for the overflowing trashcan.
-She was at the facility a couple of weeks ago

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C 078	Continued From page 14 and the bathrooms and bedrooms were clean; the staff did not know she was coming so maybe that was why it was clean. -Staff were responsible for cleaning the bathtubs, floors, sinks, mirrors, fixtures, toilet and base of the toilet when they cleaned the bathrooms; there was a list. -There was a laundry schedule for the residents; the staff were responsible for washing, folding and putting away the resident's laundry.	C 078		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure at least four fire drills were performed each year. The findings are: Review of the fire and disaster drill log revealed the last documented fire drill was conducted on 10/22/20 at 1:00pm and six residents took three	C 100		

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C 100	Continued From page 15 minutes to evacuate the facility. Observation of a fire drill conducted byt the Supervisor-in-Charge (SIC) on 04/15/21 at 7:28pm revealed: -Four residents were seated in the living room and one resident was in her bedroom. -The SIC used her cell phone to mimic the sound of a fire alarm and stood at the back of the common hallway out of view of the residents. -None of the residents responded to the sound of the alarm; each resident remained seated and were unphased by the alarm noise. -One of the residents commented the noise sounded like an alarm of some sort but did not attempt to exit the facility. -After approximately four minutes, the SIC abandoned the attempt to conduct the fire drill. Interview with a resident on 04/15/21 at 7:30pm revealed they had not had a fire drill in so long she could not remember the last time one was done. Interview with the SIC on 04/15/21 at 1:05pm revealed: -She had not been trained on fire safety. -She was not trained on how to perform fire drills and did not know how to complete a fire drill. Interview with another SIC on 04/15/21 at 5:36pm revealed: -She used to perform fire drills when she worked during the day. -Since she had started working night shift, she had not performed a fire drill. -She was scared to take the residents outside in the dark. -It had been a very long time since she performed a fire drill.	C 100		

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C 100	Continued From page 16 -When she completed a fire drill, she would find an alarm on her cell phone; when the fire drill started, she would instruct the residents to exit the front door and walk towards the bushes outside so she could make sure everyone was out of the home. Telephone interview with the Administrator on 04/16/21 at 3:49pm revealed: -Fire drills were supposed to be conducted once a month and documented. -All the residents could exit safely during a fire drill. -She did not know the last time a fire drill had been conducted. -She did not know the last time she had reviewed the fire drill logs. -All staff knew to conduct the fire drills except the one new staff because she had not trained them how yet.	C 100		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all electrical equipment was maintained in a safe operating condition related	C 102		

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C 102	Continued From page 17 to a missing light fixture in the common hallway, bedside lamps without lampshades in two resident bedrooms, and a ceiling heater that was not properly supported in the ceiling. The findings are: Observation of resident bedroom #2 on 04/14/21 at 4:08pm revealed there was a lamp sitting on the dresser without a lampshade and just an exposed lightbulb. Interview with the resident, who resided in resident room #2, on 04/14/21 at 4:08pm revealed: -A lampshade would be "okay" to have but she had never said anything to anyone about the lamp missing a lampshade. -She did not know if the Administrator had noticed the missing lampshade and no one had said anything to her about the missing lampshade. Observation of resident room #4 on 04/14/21 at 10:11am revealed there was no lampshade for the lamp. Interview with the resident, who resided in resident room #4, on 04/14/21 at 10:05am revealed: -The lamp had never had a lampshade. -The Administrator never put a shade on the lamp. -The overhead light did not work, because there was not a bulb in the fixture. Observation of the hallway on 04/14/21 at 8:58am revealed the light fixture in the hallway was missing. Observation of the bathroom on the common	C 102		

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C 102	Continued From page 18	C 102		

hallway on 04/14/21 at 9:23am revealed:
-There was a small round space heater on the ceiling that had a wire cover on it; the heater was on and the heating element was bright red.
-The base of the heater was not secure and had partially separated on one side and was hanging from the ceiling.

Interview with the Supervisor-in-Charge (SIC) on 04/14/21 at 12:00pm revealed:
-She did not report missing lightbulbs or maintenance issues to the Administrator or anyone else because she figured they already knew because it was like that when she started to work at the facility.
-The ceiling heater was "like that" when she started working at the facility.
-None of the residents complained to her about the missing lightbulbs or lamp shades.

Telephone interview with the facility's landlord on 04/15/21 at 1:38pm revealed:
-She had not spoken to the Administrator about any repairs needed to the property.
-Usually the residents let her know of things that needed to be repaired.
-She went to the facility about once a month to visit a resident, but she did not tour or inspect the facility.
-She last inspected the facility before the pandemic.
-The facility staff could call her directly to report any needed repairs.
-She was responsible for the structural and electrical repairs.
-She had the ceiling heater in the common hallway bathroom repaired and secured to the ceiling 3 to 4 times in the past year.
-She spoke to an electrician about removing the heater and replacing it with something else the

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C 102	Continued From page 19 last time it was repaired; she would contact the electrician this week about removing the heater. -The Administrator and the Business Manager both had her telephone number and her email and could contact her concerning needed repairs. Telephone interview with the Administrator on 04/16/21 at 2:33pm revealed: -She had ordered two new lamps months ago; the new lamps were probably in the storage room. -She had forgotten about the new lamps but would make sure they were replaced the next time she was at the facility. -Staff only needed to tell her if there were missing light bulbs and she would supply them with a new one; she kept the lightbulbs with her. -She was going to replace some of the ceiling fans and overhead light fixtures because they kept blowing lightbulbs. -The ceiling heater in the common hallway bathroom was correctly mounted to the ceiling a couple of weeks ago; she saw the ceiling heater herself. -She understood it was still her responsibility to take care of the facility, but she needed to get help from the landlord because she could not afford to take care of everything out of her own pocket. -Staff could call the Business Manager or the landlord themselves. -She did not look at everything every time she was in the facility. -She and the landlord did not get along because of history between them, and she was not comfortable being in the facility, so she tried to let the Business Manager deal with the landlord. -She did not do inspections when she was at the facility.	C 102		

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C 140	Continued From page 20	C 140		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff sampled (Staff A, B, C) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services upon hire. The findings are: 1. Review of the facility's personnel records revealed there was no record for Staff A (Supervisor-in-Charge) in the facility and no documentation of TB testing. Interview with Staff A on 04/14/21 at 9:43am and 12:50pm revealed:	C 140		

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C 140	Continued From page 21 -She had been working at the facility a little over a month. -She began working between February and March 2021 (unsure of exact date). -She thought she had a tuberculosis test when she started. Telephone interview with the facility's contracted Registered Nurse (RN) on 04/15/21 at 3:26pm revealed: -She had just begun to administer test for TB disease to the staff on 04/02/21. -She had not tested Staff A for TB; they were not among the staff she had administered the test to. Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 2. Review of the facility's personnel records revealed there was no record for Staff B (Supervisor-in-Charge) in the facility and no documentation of TB testing. Interview with a SIC on 04/15/21 at 5:36pm revealed Staff B just started working about a week or two ago. Telephone interview with Staff B on 04/16/21 at 11:56am revealed: -She trained with the SIC at the facility for four hours on Saturday, 04/10/21. -She worked on Monday 04/12/21 all day; she worked a half a day in the morning by herself and half of the day in the afternoon with the facility's contracted Registered Nurse (RN). -She did not have a tuberculosis test done prior to starting work at the facility.	C 140		

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C 140	Continued From page 22 Telephone interview with the facility's contracted RN on 04/15/21 at 3:16pm revealed: -She had worked with Staff B on Monday, 04/12/21, for a most of the day; Staff B was there when she got to the facility at about 11:00am. -She had just begun to administer test for TB disease to the staff on 04/02/21. -She had not tested Staff B for TB; they were not among the staff she had administered the test to. Telephone interview with the Administrator on 04/15/21 at 10:14am revealed: -Staff B had only trained half a day on Saturday, 04/10/21. -Staff B did not work on 04/10/21 but just "shadowed the SIC"; Staff B was not working at the facility "yet". Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 3. Review of the facility's personnel records revealed there was no record for Staff C (Supervisor-in-Charge) in the facility and no documentation of TB testing. Interview with a SIC on 04/14/21 at 9:04am revealed Staff C worked part time on 2nd shift, on the weekends, and relieved her on her days off. Telephone interview with the facility's contracted Registered Nurse (RN) on 04/15/21 at 3:26pm revealed: -She had just begun to administer test for TB disease to the staff on 04/02/21. -She had not tested Staff C for TB; they were not	C 140		

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C 140	Continued From page 23 among the staff she had administered the test to. Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -Staff C had worked at the facility and then was off the schedule for a while due to an investigation but the Administrator had told her Staff C was cleared to return to work. -She put Staff C on the schedule to work the upcoming weekend. -She had been told by the Administrator that it was okay for Staff C to work. -Staff C was on the staff schedule to work beginning at 5:00pm on Friday, 04/16/21, to Monday, 04/19/21, at 8:00am. Telephone interview with the Administrator on 04/15/21 at 9:45pm revealed: -Staff C used to work at the facility but she had been "let go" and did not work there anymore. -She did not know why someone would say Staff C still worked there because she "definitely does not work there". Attempted telephone interview with Staff C on 04/16/21 at 12:48pm was unsuccessful. Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. _____ Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -She was responsible for making the staff schedule and the Administrator was responsible for maintaining the personnel records. -She was looking for the personnel records a couple of weeks ago and all of them were not	C 140		

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C 140	Continued From page 24 there. -She did not know where all the personnel records were; there were some personnel records in a file cabinet in the medication office. Telephone interview with the Administrator on 04/14/21 at 5:00pm revealed: -All the personnel records were at the facility once but they had disappeared or been misplaced. -She had electronically scanned all the personnel records into her computer and could get copies for the survey team. -She thought the personnel records where filed in the office at the facility. -She was responsible for the personnel records. Documentation of staff's TB skin testing was requested on 04/14/21 at 5:00pm but was not provided by survey exit. _____ The facility failed to ensure all staff had TB skin testing completed upon hire, which placed the residents at increased risk for exposure to and transmission of tuberculosis disease. The facility's failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2021.	C 140		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications	C 145		

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C 145	Continued From page 25 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, B, C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of the facility's personnel records revealed there was no record for Staff A (Supervisor-in-Charge) in the facility and no documentation of an HCPR check upon hire. Interview with Staff A on 04/14/21 at 12:50pm revealed: -She had been working at the facility a little over a month. -She began working between February and March 2021 (unsure of exact date). Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 2. Review of the facility's personnel records revealed there was no record for Staff B, Supervisor-in-Charge (SIC) in the facility and no	C 145		

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C 145	Continued From page 26 documentation of an HCPR check upon hire. Telephone interview with Staff B on 04/16/21 at 11:56am revealed: -She trained with the SIC at the facility for four hours on Saturday, 04/10/21. -She worked on Monday, 04/12/21, all day; she worked a half a day in the morning by herself and half of the day in the afternoon with the facility's contracted Registered Nurse (RN). Interview with a SIC on 04/15/21 at 5:36pm revealed Staff B just started working about a week or two ago. Telephone interview with the facility's contracted RN on 04/15/21 at 3:16pm revealed: -She had worked with Staff B on Monday, 04/12/21, for a most of the day. -Staff B was alone at the facility when she got there at about 11:00am. Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -Staff B was in the process of being trained; she had trained last Saturday, 04/10/21, with the SIC and worked with the facility's contracted RN on Monday (04/12/21). -Staff B was alone from 7:00am until the facility's contracted RN came in with her on 04/12/21. Telephone interview with the Administrator on 04/15/21 at 10:14am revealed: -Staff B had only trained half a day on Saturday, 04/10/21. -Staff B did not work on 04/10/21 but just "shadowed the SIC"; Staff B was not working at the facility "yet". Refer to the telephone interview with the facility's	C 145		

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C 145	Continued From page 27 Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 3. Review of the facility's personnel records revealed there was no record for Staff C (Supervisor-in-Charge) in the facility and no documentation of an HCPR check upon hire. Interview with a SIC on 04/14/21 at 9:04am revealed Staff C worked part time on 2nd shift, on the weekends, and relieved her on her days off. Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -Staff C had worked at the facility and then was off the schedule for a while, but the Administrator had told her Staff C was cleared to return to work. -She had been told by the Administrator that it was "okay" for Staff C to work so she put Staff C on the schedule to work the upcoming weekend. -Staff C was on the staff schedule to work beginning at 5:00pm on Friday, 04/16/21, to Monday, 04/19/21, at 8:00am. Telephone interview with the Administrator on 04/15/21 at 9:45pm revealed: -Staff C used to work at the facility but she had been "let go" and did not work there anymore. -She did not know why someone would say Staff C still worked there because she "definitely does not work there". Attempted telephone interview with Staff C on 04/16/21 at 12:48pm was unsuccessful. Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am.	C 145		

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	FCL093012	A. BUILDING: _____ B. WING _____	04/16/2021

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C 145	Continued From page 28 Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. _____ Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -She was responsible for making the personnel schedule and the Administrator was responsible for maintaining the personnel records. -She was looking for all the personnel records a couple of weeks ago and all of them were not there. -She did not know where all the personnel records were; there were some personnel records in a file cabinet in the medication office. Telephone interview with the Administrator on 04/14/21 at 5:00pm revealed: -All the personnel records were at the facility once but they had disappeared or been misplaced. -She had electronically scanned all the personnel records into her computer and could get copies for the survey team. -She thought the personnel records where filed in the office at the facility. -She was responsible for the personnel records. Documentation of staff's health care personnel registry checks was requested on 04/14/21 at 5:00pm but was not provided by survey exit. _____ The facility failed to assure Staff A, B, and C did not have substantiated findings listed on the Health Care Personnel Registry (HCPR) prior to working at the facility. The facility's failure resulted in it being unknown if staff had substantiated findings on the HCPR, which was detrimental to the health, welfare, and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in	C 145		

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C 145	Continued From page 29 accordance with G.S. 131D-34 on 04/16/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2021.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff, (Staff A, B, C), had a criminal background check completed upon hire. The findings are: 1. Review of the facility's personnel records revealed there was no record for Staff A, Supervisor-in-Charge (SIC) in the facility and no documentation of a criminal background check completed upon hire. Interview with Staff A on 04/14/21 at 12:50pm revealed: -She had been working at the facility a little over a month. -She began working between February and March 2021 (unsure of exact date).	C 147		

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C 147	Continued From page 30 Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 2. Review of the facility's personnel records revealed there was no record for Staff B, Supervisor-in-Charge (SIC) in the facility and no documentation of a criminal background check completed upon hire. Telephone interview with Staff B on 04/16/21 at 11:56am revealed: -She trained with the SIC at the facility for four hours on Saturday, 04/10/21. -She worked on Monday, 04/12/21, all day; she worked a half a day in the morning by herself and half of the day in the afternoon with the facility's contracted Registered Nurse (RN). Interview with a SIC on 04/15/21 at 5:36pm revealed: -Staff B just started working about a week or two ago. -She only worked with Staff B one time for a half a day last Saturday (04/10/21). -She trained Staff B for a half a day before she got off. -She had not seen Staff B since then. -Staff B was on the schedule to work this past Monday (04/12/21), but she did not work with Staff B that day. Telephone interview with the facility's contracted RN on 04/15/21 at 3:16pm revealed: -She had worked with Staff B on Monday, 04/12/21, for a most of the day. -Staff B was alone at the facility when she got	C 147		

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C 147	Continued From page 31 there at about 11:00am. Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -Staff B was in the process of being trained; she had trained last Saturday, 04/10/21, with the SIC and worked with the facility's contracted RN on Monday (04/12/21). -Staff B was alone from 7:00am until the facility's contracted RN came in with her on 04/12/21. Telephone interview with the Administrator on 04/15/21 at 10:14am revealed: -Staff B had only trained half a day on Saturday, 04/10/21. -Staff B did not work on 04/10/21 but just "shadowed the SIC"; Staff B was not working at the facility "yet". Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 3. Review of the facility's personnel records revealed there was no record for Staff C (Supervisor-in-Charge) in the facility and no documentation of a criminal background check completed upon hire. Interview with a SIC on 04/14/21 at 9:04am revealed Staff C worked part time on 2nd shift and weekends and relieved her on her days off. Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -Staff C had worked at the facility and then was off the schedule for a while, but the Administrator had told her Staff C was cleared to return to work.	C 147		

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C 147	Continued From page 32 -She had been told by the Administrator that it was "okay" for Staff C to work so she put Staff C on the schedule to work the upcoming weekend. -Staff C was on the staff schedule to work beginning at 5:00pm on Friday, 04/16/21, to Monday, 04/19/21, at 8:00am. Telephone interview with the Administrator on 04/15/21 at 9:45pm revealed: -Staff C used to work at the facility but she had been "let go" and did not work there anymore. -She did not know why someone would say Staff C still worked there because she "definitely does not work there". Attempted telephone interview with Staff C on 04/16/21 at 12:48pm was unsuccessful. Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. _____ Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -She was responsible for making the personnel schedule and the Administrator was responsible for maintaining the personnel records. -She was looking for the personnel records a couple of weeks ago and all of them were not there. -She did not know where all the personnel records were; there were some personnel records in a file cabinet in the medication office. Telephone interview with the Administrator on 04/14/21 at 5:00pm revealed: -All the personnel records were at the facility once but they had disappeared or been misplaced.	C 147		

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C 147	Continued From page 33 -She had electronically scanned all the personnel records into her computer and could get copies for the survey team. -She thought the personnel records where filed in the office at the facility. -She was responsible for the personnel records. Documentation of staff's criminal background checks being completed was requested on 04/14/21 at 5:00pm but was not provided by survey exit. _____ The facility failed to ensure 3 of 3 staff had a criminal background check completed prior to hire. The facility's failure resulted in it being unknown if Staff A, B, and C had a criminal history which was detrimental to the safety and welfare of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with 131D-34 on 04/16/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 31, 2021.	C 147		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter.	C 185		

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C 185	Continued From page 34 The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules for family care homes related to outside entrances and exits, test for tuberculosis, other staff qualifications, and adult care home medication aide training and competency evaluation requirements. The findings are: Interview with a resident on 04/14/21 at 10:05am revealed he had not seen the Administrator since last month. Interview with a second resident on 04/15/21 at 12:44pm revealed: -She had seen the Administrator at the facility about a month ago and the Administrator stayed about an hour. -The Administrator asked her if there were any problems. Interview with a third resident on 04/15/21 at 1:02pm revealed the last time she saw the Administrator was about a month ago, between February and March 2021.	C 185		

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C 185	Continued From page 35 Interview with the Supervisor-in-Charge (SIC) on 04/15/21 at 10:20am and 1:18pm revealed: -The Administrator did not come into the facility and did not work shifts for the staff; the staff relieved each other when they needed the time off. -The Administrator did not come to the facility very often; the last time was over two weeks ago. -She walked around and talked to the residents; she never had a note book or made notes while she was there. -She stayed for about an hour. -She did not bring the groceries to the facility; someone else brought them. Telephone interview with the facility's contracted Registered Nurse (RN) on 04/15/21 at 3:36pm revealed: -The Administrator "normally" came to the facility at least once a month. -The Administrator never stayed at the facility over night or to relieve staff if short staffed. -She had covered the facility "a lot" and had done more than she was contracted to do; she was the Licensed Health Professional Support (LHPS) nurse. -She had told the Administrator she needed to make more visits and assist in the facility, but the Administrator had not done so. -She was at the facility more often than the Administrator; the Administrator did not spend enough time at the facility. -She had expressed her concerns about one of the residents to the Administrator and there was a lack of concern about the resident from the Administrator. -She did not see the Administrator at the facility when she was there. -The Administrator came to the facility once a	C 185		

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C 185	Continued From page 36 month on the 6th to give the residents their money and she only stayed an hour. Telephone interview with the Administrator on 04/14/21 at 2:33pm revealed she had not been in the facility since 03/18/21. Noncompliance was identified at violation level in the following rule areas: 1. Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with a resident's assessed needs, care plan and current symptoms for 1 of 3 sampled residents (#1) who was reported missing to local law enforcement and was known to go leave the facility unsupervised to go into the community seeking rides, food, money and cigarettes. [Refer to tag C0243, 10A NCAC 13G. 0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors had an alarm that was activated and sounded when the door was opened to alert staff for 1 of 1 residents (#1), who was known to wander into the community unsupervised. [Refer to tag C0069, 10A NCAC 13G. 0312(g) Outside Entrances and Exits. (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff sampled (Staff A, B, C) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services upon hire. [Refer to tag C0140, 10A NCAC 13G. 0405(a) Test for Tuberculosis (Type B Violation)]. 4. Based on interviews, and record reviews, the	C 185		

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C 185	Continued From page 37 facility failed to ensure 3 of 3 sampled staff (Staff A, B, C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to tag C0145, 10A NCAC 13G. 0406(a)(5) Other Staff Qualifications (Type B Violation)]. 5. Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff, (Staff A, B, C), had a criminal background check completed upon hire.]Refer to tag C0147, 10A NCAC 13G. 0407(a)(7) Other Staff Qualifications (Type B Violation)]. 6. Based on interviews and record reviews, the facility failed to ensure 1 of 1 staff sampled (Staff A) who administered medications had completed a 5, 10 or 15 hour mandated medication aide training, completed their medication clinical skills competency validation prior to administering medications. [Refer to tag C935, G.S. 131D-21 4.5B(b) Adult Care Home Medication Aide Training and Competency (Continuing Unabataed Type B Violation)]. _____ The Administrator failed to ensure the overall management, operations, and policies of the facility were implemented by failing to ensure Resident #1, who wandered and was ajudicated incompetent, leaving the facility unsupervised on multiple occasions without staff knowing her whereabouts; outside entrances had an alarm that was activated and sounded when opened to alert staff that Resident #1 had left the facility; a medication aide, who was solely responsible for the care of the residents, was trained in medication administration which resulted in Resident #1 not being administered a medication used to treat diabetes and Resident #3 not being administered a medication used to control pain	C 185		

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C 185	Continued From page 38 because it was not available; and staff qualifications, including testing for tuberculosis, criminal background checks, and health care personnel registry checks were completed upon hire for three staff. This failure of the Administrator resulted in substantial risk for serious physical harm and neglect of the residents' which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/16/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 16, 2021.	C 185		
C 232	10A NCAC 13G .0801 (c) Resident Assessment 10A NCAC 13G .0801Residents Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment	C 232		

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C 232	Continued From page 39 for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being over a period of time such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 1 of 3 sampled residents (#1) who declined and was dependent on staff for assistance with transferring, had become incontinent, was having increased behaviors, and increased falls. The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed:	C 232		

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C 232	Continued From page 40 -Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia. -Resident #1 was intermittently disoriented. -Resident #1 was incontinent. Review of Resident #1's Care Plan dated 10/08/20 revealed: -She was sometimes disoriented, forgetful and needed reminders. -Resident #1 had wandering, disruptive and socially inappropriate behaviors. -Resident #1 had slurred speech. -Resident #1 needed limited assistance with eating, ambulation and grooming. -Resident #1 needed extensive assistance with toileting bathing and dressing. -Nothing was documented for Resident #1 related to transferring. Observation of Resident #1 on 04/14/21 at 4:27pm and 4:35pm revealed: -Resident #1 shuffled her feet when she walked. -Resident #1 could not lift her left leg to step up and into the entrance of the facility; another resident lifted Resident #1's leg up so she could come into the facility. Interview with Resident #1 on 04/14/21 at 9:58pm revealed: -She had something wrong with her legs and she could barely stand up. -She would call for the staff to help her get out of the bed. -She had to wear adult briefs; she did not like it, but she could not help herself and needed staff to help her change. Interview with a Supervisor-in-Charge (SIC) on 04/15/21 at 1:24pm revealed:	C 232		

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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
C 232	Continued From page 41 -Resident #1 would call for her when she needed help getting out of the bed. -She would help Resident #1 get to her feet by holding her hands and guiding her up. -Resident #1 would slide out of the bed and end up on the floor when she tried to stand on her own. Telephone interview with the facility's contracted Registered Nurse (RN) on 04/15/21 at 3:22pm revealed: -She had noticed a change in Resident #1 both cognitively and physically over the last month or so. -She was concerned about Resident #1 because she was having more falls and having more behavioral issues which was contributing to her desire to go into the community unsupervised. -She was not aware another resident assessment would need to be completed for Resident #1 due to the changes in her condition. -Resident #1 was scheduled to see a specialist and she would see about having an assessment done after that visit. Telephone interview with the Administrator on 04/14/21 at 5:15pm revealed: -Resident #1 had a significant change in her condition; Resident #1 was "slipping", and she had noticed it in the last couple of weeks. -Resident #1 would slide out of the bed while trying to stand. -Over the past month Resident #1 had increased falls; on 04/09/21, Resident #1 went to the hospital after sliding while trying to get out of bed. -In the last month, Resident #1 had stumbled and fell while outside the facility. -In the last week or two, Resident #1 had begun to shuffle her feet while walking. -Resident #1 had declined physically, her	C 232		

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C 232	Continued From page 42 behaviors had increased, and she was acting out more. -Resident #1 was now incontinent and wore adult briefs, needed assistance getting out of bed, shuffled her feet when she walked and was falling more frequently. -Resident #1 had a scheduled appointment with her primary care provider (PCP) and a scheduled appointment with a Neurologist on 04/15/21. -She was not aware Resident #1 needed a new assessment due to her significant change in her condition; she would have the PCP, or the facility's contracted Registered Nurse complete a new one for Resident #1. Attempted interview with Resident #1 PCP on 04/15/21 at 8:18am was unsuccessful.	C 232		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the personal care needs for 1 of 3 residents (#1) were met by not changing an adult brief that resulted in the resident having wet clothes and wet sheets. The findings are:	C 242		

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C 242	Continued From page 43 Review of Resident #1's current FL-2 dated 03/08/21 revealed: -Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia. -Resident #1 was intermittently disoriented. -Resident #1 was incontinent. Review of Resident #1's Care Plan dated 10/08/20 revealed: -She was sometimes disoriented, forgetful and needed reminders. -Resident #1 had disruptive and socially inappropriate behaviors. -Resident #1 needed limited assistance with eating, ambulation and grooming. -Resident #1 needed extensive assistance with toileting bathing and dressing. -Nothing was documented for Resident #1 related to transferring. Review of Resident #1's Licensed Health Professional Support (LHPS) task list dated 01/12/21 revealed staff were to encourage Resident #1 with timing for toileting. Observation on 04/15/21 at 10:20am revealed Resident #1 told the Supervisor-in-Charge (SIC) her bed sheets needed changing because they were wet. Observation of Resident #1 on 04/15/21 at 1:00pm revealed the resident had on a pair of gray pants with a large wet area from her left groin down to her knee. Observation of Resident #1 on 04/15/21 at 7:13pm revealed the resident had on the same gray pants and the previously wet area was dry.	C 242		

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C 242	Continued From page 44 Interview with Resident #1 on 04/14/21 at 9:58pm revealed: -She had something wrong with her legs and she could barely stand up. -She would call for the staff to help her get out of the bed. -She had to wear adult briefs; she did not like it, but she could not help herself and needed staff to help her change. Review of Resident #1's progress notes for March 2021 and April 2021 revealed: -On 03/03/21, Resident #1 complained she could not get out of the bed on her own; she fell twice during the night without injury but was hard to get up; and she would try to get out of the bed, go to the bathroom on her own and she had wet herself and soiled her brief. -On 03/05/21, the SIC noted Resident #1 had two bowel movements on herself and was only allowed two adult briefs a day. -On 03/31/21, the SIC gave Resident #1 two adult briefs at 8:15am and she wet them both. -On 03/31/21, at 5:35pm the SIC gave Resident #1 two more adult briefs. -On 04/03/21, at 3:00am Resident #1 woke up wet and asked for a new adult brief. Interview with the SIC on 04/15/21 at 10:34am and 1:24pm revealed: -Resident #1 changed her own briefs and was given two pairs at the beginning of the day. -Resident #1 was encouraged to get up and go to the bathroom on her own. -Sometimes Resident #1 would sleep and refuse to get up and go to the bathroom. -She would try to wake Resident #1 every two hours to get her to go to the bathroom. -She was told to get Resident #1 up, so she did not wet the bed or her adult brief.	C 242		

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C 242	Continued From page 45 -Sometimes Resident #1 would soak her adult brief and her sheets would get wet; Resident #1 would let her know and she would wash them for her. Telephone interview with the facility's contracted Registered Nurse (RN) on 04/15/21 at 3:48pm revealed: -Resident #1 would slide off the bed and turn on her knees to get out of the bed; it was as if her legs were weak. -Resident #1 had an order for adult briefs; she was having increased incidents of incontinence since about December 2020 or January 2021. -She had told the staff to encourage Resident #1 to go to the bathroom on her own and to time her toileting to help her go on her own. Telephone interview with the Administrator on 04/14/21 at 5:00pm revealed: -Resident #1 had an order for adult briefs; her primary care physician (PCP) had written the order for her to have them. -There were plenty of adult briefs in the storage room at the facility for Resident #1 she did not know why the staff limited her to two a day; she had not told them to do that. -She had told the staff to get Resident #1 up during the day and get her to the bathroom and try to get her to use the toilet. -Resident #1 would lay in the bed and wet her brief and herself rather than get up and go to the bathroom. -Resident #1 had declined over the past month or so and had begun to be incontinent to bladder and bowel and had to wear adult briefs. Attempted interview with Resident #1's PCP on 04/15/21 at 8:18am was unsuccessful.	C 242		

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C 243	Continued From page 46	C 243		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect or exploitation will occur. THIS IS A TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with a resident's assessed needs, care plan and current symptoms for 1 of 3 sampled residents (#1) who was reported missing to local law enforcement and was known to go leave the facility unsupervised to go into the community seeking rides, food, money and cigarettes. The findings are: Observation of the facility on 04/15/21 from 6:35pm to 7:09pm revealed: -Resident #1 left the facility unsupervised and the Supervisor-in-Charge (SIC) was beginning to search the yard of the facility for her. -At 6:40pm, the Administrator came to the facility and was informed by the SIC that Resident #1 had left without permission for the second time that day.	C 243		

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-The Administrator left via car to search the area for Resident #1.
-At 7:09pm Resident #1 returned on her own and reported to the SIC and the Administrator that she had gone to see a neighbor; that is all the information Resident #1 would share.
-Resident #1 had candy in her pockets when she returned.

Review of Resident #1's current FL-2 dated 03/08/21 revealed:
-Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia.
-Resident #1 was intermittently disoriented.
-Resident #1 was incontinent.

Review of Resident #1's Resident Register revealed:
-There was an admission date of 09/23/20.
-Resident #1 had a guardian.

Review of Resident #1's Care Plan dated 10/08/20 revealed:
-She was sometimes disoriented, forgetful and needed reminders.
-Resident #1 had wandering, disruptive and socially inappropriate behaviors.
-Resident #1 had slurred speech.
-There were no interventions to address behaviors or supervision needs.

Review of Resident #1's primary care physician's (PCP)'s visit note dated 03/18/21 revealed Resident #1 should be supervised when leaving the facility for safety reasons.

Review of staff notes dated March 2021 and April 2021 revealed:
-Resident #1 left the facility without supervision

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C 243	Continued From page 48 once on 03/03/21, twice on 03/11/21, twice on 03/23/21, once on 03/26/21 and once on 03/27/21. -On 03/11/21, someone in the community reported to the local police department (LPD) Resident #1 was flagging down cars in the street. -On 03/16/21, a staff noted Resident #1 was very disoriented and "acted up the entire shift". -On 03/25/21, the local police department was called because Resident #1 became combative with the facility's contracted Registered Nurse (RN) and grabbed the RN's arm when she tried to tell Resident #1 not to leave the facility. -On 03/26/21, the Adult Home Specialist (AHS) from the local county Department of Social Services observed Resident #1 attempting to flag down cars from the middle of the street; the AHS informed the facility of Resident #1's whereabouts. -On 04/05/21, Resident #1 left the facility unsupervised and returned via a car with a stranger; she returned with cigarettes and money. -On 04/06/21, Resident #1 left the facility unsupervised and returned via a different car from the day before with a different stranger; she returned with cigarettes, snacks and money. Review of local law enforcement reports from the LPD dated November 2020 revealed: -On 11/05/20, the LPD responded to a call from the facility because Resident #1 had walked away from the facility; the LPD had located Resident #1 and returned her to the facility. -On 11/09/20, the LPD responded to a call from the facility because Resident #1 had become combative and left the facility. -On 11/09/20, the LPD responded to another call from the facility because Resident #1 had left the facility; the LPD located Resident #1.	C 243		

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C 243	Continued From page 49 Review of police reports from the LPD dated March 2021 revealed on 03/12/21 the LPD responded to call from the facility because Resident #1 had left the facility unsupervised and was missing. Interview with Resident #1 on 04/15/21 at 12:44pm revealed: -She would forget to sign out or let the staff know she was leaving the facility. -The staff knew when she left because they were always looking for her when she would get back to the facility. -The staff did not like her to leave. -"I can go out on my own". -The "doctor" did not want her to go out by herself because she might fall; "I can take care of myself". -She could not get from one point to another so she would catch rides to places from people she did not know. -She would go to the store; she did not have money, but she would ask the "nice people of the world" to help her out. -Some people would buy her cigarettes or offer her food or money. -She did not know any strangers because everyone was nice to her. -The Administrator had told her that she was worried about her. -She never felt anxious; she was always relaxed. Interview with the SIC on 04/14/21 at 9:10am and 4:17pm revealed: -Resident #1 wandered; she left the facility and was unsupervised on Wednesday (04/07/21) the week before. -When Resident #1 would leave unsupervised, she would go outside and call Resident #1's name.	C 243		

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C 243	Continued From page 50 -She called the Administrator to let her know when Resident #1 left the facility without permission. -The Administrator told her to notify the LPD when Resident #1 was gone for over an hour. -She had not had to call 911 and report Resident #1 as missing because when she worked Resident #1 would return in less than an hour when she left unsupervised. -Resident #1 usually went to the neighbor's house or to the house behind the facility, but she always came back. Interview with the same SIC on 04/15/21 at 9:36am revealed: -Resident #1 would get anxious and want to leave the facility. -Resident #1 would want to do things like smoke. -Resident #1 would argue with other residents when she would get anxious and then want to leave the facility. -Resident #1 would go to the store, walk around the community, try to flag down cars, and go out to get cigarettes or money. -Resident #1 would get her mind stuck on one thing and then she would get anxious and leave. Interview with the AHS on 04/15/21 at 7:45am revealed: -She had received multiple telephone calls from concerned community citizens that Resident #1 was walking in the middle of the road, on the yellow line attempting to "hitchhike." -One citizen stated that Resident #1 was observed being returned back to the facility in a car with a male driver. -On 03/26/21 at 5:08pm, the AHS was on her way home and observed Resident #1 walking down the street on the sidewalk. -Resident #1 appeared to be about several	C 243		

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C 243	Continued From page 51 houses away from the facility. -She pulled over and requested Resident #1 to come to the car. -Resident #1 remembered who the AHS was. -She asked Resident #1 why she was not at the facility; Resident #1 stated she was trying to hitchhike to the store. -She instructed Resident #1 several times to return back to the facility. -The facility's contracted Registered Nurse (RN) stated staff had attempted to keep Resident #1 at the facility, but she refused to stay and would leave the facility. -The facility's contracted RN said when Resident #1 returned to the facility, she often came back with food, money and cigarettes. -While she was talking with the SIC and the facility's contracted RN, she observed Resident #1 walking back to the facility. -Resident #1 was walking as if her gait was unstable. -Resident #1 stopped and started talking to the people in the house across the street from the facility. -She instructed Resident #1 to come in the yard. -She instructed the SIC to contact the police and request an involuntary committed (IVC) if Resident #1 eloped again over the weekend. -At 6:30pm, the Administrator contacted her to let her know staff contacted her and informed her of Resident #1's elopement. -The Administrator stated that Resident #1 had a medication change in hopes to assist Resident #1 with her "nervousness." -The Administrator hoped the medication would help calm Resident #1 and keep her from eloping. Telephone interview with the facility's contracted RN revealed:	C 243		

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-Resident #1 did not want to follow rules and was very childlike.
-Resident #1 would get restless or anxious and could not sit still and then want to leave the facility.
-Resident #1 was not safe at the facility because she wanted to "roam".
-She was afraid something would happen to Resident #1 when she left the facility unsupervised.
-She had shared her concerns with the Administrator since Resident #1 had been admitted to the facility.

Telephone interview with a medical assistant from Resident #1 primary care provider's (PCP) office on 04/16/21 revealed:
-The PCP did not want Resident #1 leaving the facility unsupervised because she purchased inappropriate foods and was at risk for falls.
-Resident #1 was on a diabetic diet and she was to restrict carbohydrates, prepackaged meals and snack foods.

Telephone interview with Resident #1's mental health provider on 04/16/21 at 1:07pm revealed:
-Resident #1 was confused at times, angry and agitated.
-She had concerns for Resident #1's safety if she was in the community without supervision.
-Resident #1 had suffered a decline in her personal needs and had been to the hospital due to recent falls.
-Resident #1 was scheduled to see a Neurologist on 04/15/21 to determine if her cognitive issues were related to dementia or behavioral.
-Resident #1 could be easily agitated and needed redirection.
-Resident #1 did not have the cognitive ability to make sound judgement decisions concerning her

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C 243	Continued From page 53 safety. -Resident #1 could not recognize unsafe situations like getting into a car with a stranger or walking down the middle of the street. Telephone interview with Resident #1's guardian on 04/16/21 at 1:56pm revealed: -Resident #1 had been deemed incompetent, which waswhy she had a guardian. -There was a concern in general for Resident #1's safety when she was out in the community alone. -Resident #1 did not recognize consequences of risky behavior like walking down the middle of the street, asking strangers for money, or getting into cars with strangers. -If Resident #1 wanted something, she would not see anything wrong with getting in a stranger's car. Telephone interview with the Administrator on 04/14/21 at 5:00pm revealed: -Because the residents were adults, they had the right to leave but needed to sign out when they were leaving. -When the residents signed out, they included the time they left, where they were going and when they would be back to the facility. -Residents were considered leaving without permission or "eloped" when they did not sign out to leave the facility. -The staff were supposed to call 911 and report Resident #1 as missing when she was gone for one hour and had not returned. -The staff had to call 911 about a month ago because Resident #1 was gone for an hour and they did not know where she was. -Resident #1 had gotten better and would come back to the facility on her own; she usually went to the store and bought junk food.	C 243		

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C 243	Continued From page 54 -About two months ago she had started the process to relocate Resident #1 because of some of her behaviors. -Resident #1's PCP changed some of Resident #1's medication last month and she wanted to see if it helped with the behaviors before she moved her. -Resident #1 had a decline in the last couple of weeks. -She had wanted to keep Resident #1 at the facility and help her, but maybe it was time to reconsider moving her somewhere else. Telephone interview with the Administrator on 04/16/21 at 2:15pm revealed: -Resident #1 had left the facility unsupervised that day (04/16/21) and had been gone for one and a half hours. -The staff had called 911 to report the elopement. -Resident #1 came back on her own. -She was concerned about Resident #1's safety when the resident left the facility unsupervised because she ate outside of her diet. -Resident #1 would go into people's homes she did not know and put herself into situations with people [strangers] in the community that were not safe. -She was concerned Resident #1 did not recognize situations as being unsafe. -There was nothing she could do to keep Resident #1 out of the road or from getting into cars with strangers. -She was awaiting a diagnosis for Resident #1 from the Neurologist and hoped that would help with the appropriate medication for Resident #1. _____ The facility failed to provide supervision to Resident #1 who was adjudicated incompetent and appointed a guardian, had a diagnosis of schizophrenia, was intermittently disoriented and	C 243		

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C 243	Continued From page 55 had a history of wandering behaviors resulting in the resident leaving the facility unsupervised on multiple occasions to wander in the community without staff knowing her whereabouts. The resident's primary care physician wrote sn order dated 03/18/21 that she should not leave the facility unsupervised for safety reasons. Resident #1's mental health provider and legal guardian had concerns about the resident's cognitive ability to recognize unsafe behaviors like walking down the middle of the street, waving down cars and accepting rides from strangers while being unsupervised in the community. These failures resulted in Resident #1 walking in the middle of the road, accepting ride from strangers, asking strangers for food and money and consuming foods outside of her diabetic diet which placed her at substantial risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ A plan of protection was provided by the facility in accordance with G.S. 131D-34 on 04/14/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 16, 2021.	C 243		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.	C 270		

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C 270	Continued From page 56 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 1 of 3 sampled residents (#1) with physician orders for a diabetic diet (#1). The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed: -Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia. -Resident #1 did not have a diet ordered. Review of a hospital discharge summary dated 03/29/21 revealed Resident #1 was on a restrictive diabetic diet; . Observation of the kitchen on 04/14/21 at 8:50am revealed: -There was no weekly menu and no therapeutic diet menu posted for staff to follow. -There was not diet list for the staff to follow. -There were no sugar free items, food or snack, available for residents on a diabetic diet. Observation of the lunch meal on 04/14/21 from 12:13pm to 12:30pm revealed: -All the residents were served the same meal; meatloaf, mixed vegetables, a wheat roll, and water. -Resident #1 ate 1/3 of the meatloaf, roll and mixed vegetables. Interview with Resident #1 on 04/15/21 at 12:44pm revealed: -She was not on a special diet. -She was told by the physician not to eat sugary	C 270		

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C 270	Continued From page 57 snacks and sodas. Interview with the Supervisor-in-Charge (SIC) on 04/14/21 at 10:02am revealed: -The nighttime SIC usually took something out of the freezer for the dinner meal. -There was not a menu to follow; she usually looked to see what food the facility had and made a meal. -Only one resident was on a therapeutic diet. -Resident #1 was not supposed to have sugar. -She had been told by the facility's contracted Registered Nurse (RN) not to serve Resident #1 any soda; that was all she was told. -She had sugar free beverages but that was the only sugar free item she had to offer Resident #1. Interview with a second SIC on 04/15/21 at 4:45pm revealed: -She did not have a menu to follow; she always made her own menu. -She did not know what to prepare for meals, so she looked to see what [food] was there and made sure the residents had a meat, two vegetables or a meat, a vegetable and a fruit. -None of the residents were on a special diet. Telephone interview with a medical assistant from Resident #1's primary care physician (PCP) on 04/16/21 at 8:52am revealed Resident #1 had a 2000 calorie diabetic diet order dated 03/18/21 to control her recently diagnosed diabetes. Telephone interview with the Administrator on 04/16/21 at 2:15pm revealed: -There was a therapeutic menu signed by a dietitian at the facility; it was kept in a binder on top of the refrigerator. -The current week's therapeutic menu should have been posted on the board in the kitchen for	C 270		

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C 270	Continued From page 58 the staff to follow. -Staff knew where it was and knew they were supposed to follow it. -The only resident on a special diet was Resident #1; she was on a No Added Sugar diabetic diet. -She did not do the shopping for the facility, so she did not know if sugar free items were purchased. -If the staff did not have a therapeutic menu posted then they were not following Resident #1's diabetic diet. The American Diabetic Association refers to a restrictive diabetic diet as a diet that restricts total carbohydrates bper day to less than 130 grams and a 2000 calorie diabetic diet as a diet than means eating no more than 2000 calories of food from an exhange list each day to control blood sugar.	C 270		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to develop and implement an activity program that promoted active involvement for the residents who resided in the facility. The findings are: Observations on 04/14/21 at 4:30pm and 5:30pm revealed:	C 288		

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C 288	Continued From page 59 -There was a desk next to the telephone with coloring books and pens. -There was not an activities calendar posted. Interview with a resident on 04/15/21 at 12:44pm revealed: -She watched television most of the day. -The facility needed new games; maybe an action game like "Operation". -She would do activities if they were offered but no staff offered to play or do any activities with her. -She got bored with nothing to do all day. -She would like to color if there was something to color. -She would like to do something fun for a change. -She would like the staff to organize something for her to do. Interview with a second resident on 04/15/21 at 1:02pm revealed: -There were no group activities in the facility. -She stayed in her room to watch television and did crossword puzzles. -It had been a long time since the residents were asked to participate in any activities. -When she first arrived to the facility, the residents used to have board games and would make artwork, but that had been "a long time ago." -When one [named] Supervisor-in-Charge (SIC) worked, she would bring things for the residents to do. -The SIC would take the residents outside to do activities, but she had not seen the [named] SIC in a while. -She would participate in activities if they were offered as long as she was taught how to do the activity. -She would get bored "a lot" because she never	C 288		

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C 288	Continued From page 60	C 288		

went anywhere.
-Her family member used to come and take her out or to get her hair done, but since the pandemic, she was not able to go anywhere.

Interview with the Supervisor-in-Charge (SIC) on 04/14/21 at 4:15pm revealed:
-No one had talked to her about or trained her about an activities programs.
-She had never seen a calendar for activities at the facility.
-She never offered any activities to the residents.
-There were coloring books and some games for the residents if they wanted them, but no one ever asked for them.
-She thought some of the residents would like to do something if activities were offered.

Second interview with the SIC on 04/15/21 at 9:36am revealed:
-There was a resident who would act out at times.
-The resident's mental health provider instructed her to put the resident's mind on something else like an activity to keep them occupied, but she had nothing for the resident to do.

Telephone interview with the Administrator on 04/14/21 at 5:15pm revealed:
-There should have been an activities calendar posted by the telephone.
-She had not trained the new SIC about activities; she had not had a chance to train yet.
-The female residents liked to color but two of the 5 residents would not participate in anything that was offered.
-Most of the residents only liked to walk to the store and smoke.
-She had a variety of activities on the calendar including television time and movie night; she could not recall the other activities that were listed

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C 288	Continued From page 61 on the calendar.	C 288		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was abated. Noncompliance continues. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (#1, #3) related to a medication used to treat diabetes not being administered correctly (#1) and a medication used to control pain not being available for administration (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia.	C 330		

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C 330	Continued From page 62 Review of Resident #1's signed physician's order dated 03/18/21 revealed there was an order for finger stick blood sugar (FSBS) checks twice daily for two weeks then check once a day thereafter. Review of Resident #1's signed physician's order dated 03/28/21 revealed: -There was an order for FSBS checks twice daily scheduled at 8:00am and 8:00pm. -There was an order for Lispro (an insulin injection used to lower blood sugar) sliding scale snsulin (SSI) before meals as follows: FSBS result less than (<) 150=0 units, 151-200=2 units, 201-250=6 units, 251-300=8 units, 301-350=10 units; greater than 351 call the primary care provider (PCP). -At bedtime if FSBS is less than 200 do not give SSI dose, if greater than 200 give 50% of SSI dose. Review of Resident #1's electronic Medication Administration Record (eMAR) for March 2021 revealed: -There was an entry for FSBS checks scheduled at 8:00am and 8:00pm; there was a space designated to document the FSBS results. -There was no documentation for FSBS on 4 out of 26 opportunities. -There was documentation for FSBS that Resident #1 was out of the facility at 8:00am on 03/30/21 and 03/31/21; other medications were documented as administered on 03/30/21 and 03/31/21 at 8:00am. -There was documentation FSBS checks were obtained on 03/30/21 and 03/31/21 at 5:00pm and 8:00pm. Review of Resident #1's eMAR for April 2021 revealed:	C 330		

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C 330	Continued From page 63 -There was an entry for FSBS checks scheduled at 8:00am and 8:00pm; there was a space designated to document the FSBS results. -There was an entry for Lispro SSI to be administered at 8:00am and 8:00pm; there was a space designate to document the FSBS results and a space designated to document the Lispro units administered. -There was documentation for FSBS obtained 8 out of 27 opportunities and SSI administrations for 7 of 25 opportunities from 04/01/21 to 04/13/21. -There was documentation on 04/01/21 at 8:00pm Resident #1's FSBS result was 214 and 2 units of Lispro were administered. Six units should have been administered per order. -There was documentation on 04/05/21 at 8:00pm Resident #1's FSBS result was 151 and nothing was documented for units of Lispro administered. Two units should have been administered per order. -There was documentation Resident #1 refused her FSBS and Lispro on 04/01/21 at 8:00am, on 04/06/21 at 8:23am, on 04/11/21 at 8:45pm, and on 04/12/21 at 8:09pm. -There was documentation Resident #1 was "awaiting physician's authorization/pharmacy mediation order" on 04/02/21, 04/03/21, and 04/04/21 at 8:00am and 04/02/21, 04/04/21, 04/06/21, and 04/08/21 at 8:00pm -There was documentation Lispro was "withheld per physician's orders" at 8:33pm on 04/03/21. -There was documentation Resident #1 was "out of the facility" on 04/05/21 at 8:56am, on 04/11/21 at 10:37am and at the hospital on 04/10/21 at 8:00am and 8:00pm. -There was documentation "condition resolved" on 04/08/21 at 10:32pm. -There was documentation medication was not given and to "see the note" but there was nothing	C 330		

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C 330	Continued From page 64 documented in the notes section for clarity on 04/12/21 at 3:36pm and on 04/13/21 at 8:22pm. Review of a FSBS log for Resident #1 for March 2021 and April 2021 revealed: -There were FSBS results documented twice daily on 03/19/21, 03/22/21, 03/31/21, and 04/14/21; the FSBS ranges were 112 to 200. -There was one FSBS result documented on each of the following dates: 03/21/21, 03/24/21, 03/26/21, 03/27/21, 03/29/21, 03/30/21, 04/01/21, 04/02/21, 04/06/21, 04/07/21, 04/08/21, 04/09/21, 04/10/21, and 04/13/21; the FSBS ranges were 26 to 214. -There was documentation of FSBS obtained 22 out of 54 opportunities. Without FSBS being obtained as ordered, the staff were unable to determine if Lispro was to be administered resulting in a medication error. Observation of medication on hand on 04/15/21 at 9:03am revealed: -There was a box of four Lispro 100 units pens in a refrigerator; the pens had a dispense date of 03/29/21. -One pen was in a resealable plastic sandwich bag; there was no open date or discard date on the pen. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 04/15/21 at 12:26pm revealed: -Resident #1 had an order for FSBS twice a day dated 03/18/21 and 03/28/21, and an order for SSI dated 03/28/21. -Five 3ml Lispro pens were dispensed on 03/29/21. Interview with Resident #1 on 04/14/21 at	C 330		

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C 330	Continued From page 65 12:03pm revealed: -She had a FSBS obtained once a day in the morning. -She let the staff do her FSBS; she did not refuse to have the FSBS done. -She did not get a shot. -She did not know what her FSBS results were. Interview with a Supervisor-in-Charge (SIC) on 04/15/21 at 12:37pm revealed: -There was a place to document the FSBS and the amount of insulin administered on the eMAR. -She also documented the FSBS on a log sheet. -She had not had to administer Lispro to Resident #1 yet. -She usually did not have to do FSBS for Resident #1 because the morning SIC did them before she started every day. -She followed the directions for the SSI that were on the eMAR. Interview with a second SIC on 04/15/21 at 4:45pm revealed: -She worked evenings and early mornings. -She had done FSBS for Resident #1, but Resident #1 did not like to have them done so they were not done every evening. -She had not had to administer Lispro to Resident #1 because her FSBS results were usually "good." Telephone interview with a medical assistant from Resident #1's PCP's office on 04/16/21 at 8:52am revealed: -The PCP was attempting to control Resident #1's blood glucose levels. -Resident #1 had an order for FSBS twice daily dated 03/18/21. -Resident #1 had an order for SSI that was dated 03/28/21.	C 330		

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C 330	Continued From page 66 -The SSI order was <150=0 units, 151-200=2 units, 201-250=6 units, 251-300=8 units, 301-350=10 units; greater than 351 call the primary care provider (PCP). -At bedtime if FSBS is less than 200 do not give SSI dose, if greater than 200 give 50% of SSI dose. -It would be difficult to monitor Resident #1's blood glucose levels if the FSBS were not being done as ordered. Telephone interview with the facility's contracted Registered Nurse (RN) on 04/15/21 at 3:33pm revealed: -Resident #1 would refuse FSBS, so the PCP agreed to check only twice daily. -Resident #1 had an order for SSI insulin and FSBS checks for twice daily. -She had instructed the staff to document the FSBS on a log sheet and on the eMAR. -Staff documented the amount of Lispro they had to administer to Resident #1 on the eMAR. -There would be no way of knowing if the Lispro SSI was being administered to Resident #1 as ordered if the FSBS were not being done as ordered. -She did not check the eMAR for administration of medication; the Administrator could remotely check the eMAR to see if there was documentation. Interview with the Administrator on 04/15/21 at 7:13pm revealed: -Resident #1 just recently started having FSBS and SSI; she often refused the FSBS. -She could remotely monitor and sign off on certain notes on the eMAR system; she monitored each medication administration. - "Waiting on pharmacy" meant the facility was waiting on the pharmacy to send the medication	C 330		

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and it was not available to administer.
-The staff should be following the order for the FSBS and the SSI if Resident #1 needed it based on the SSI order.
-Staff understood the SSI order for Resident #1 and she expected it to be administered correctly.
-She was concerned Resident #1 might not be administered her Lispro correctly because the FSBS were not being done as ordered.

2. Review of Resident #3's current FL-2 dated 12/30/20 revealed diagnoses included myasthenia gravis, major depressive disorder, hypertension, asthma, and diabetes mellitus.

Review of Resident #3's physician's orders dated 01/29/21 revealed:
-There was an order for Tramadol 50 mg (used to treat moderate to severe pain) take one tablet every 12 hours as needed.
-There were no other orders for Tramadol in Resident #3's record.

Review of Resident #3's electronic medication administration record (eMAR) for February 2021 revealed:
-There was an entry for Tramadol 50mg take one tablet every 12 hours as needed for pain.
-There was documentation of administration on 34 occasions from 02/01/21-02/28/21.

Review of Resident #3's eMAR for March 20201 revealed:
-There was an entry for Tramadol 50mg take one tablet every 12 hours as needed for pain.
-There was documentation of administration on 35 occasions from 03/01/21-03/31/21.

Review of Resident #3's eMAR for April 20201 revealed:

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-There was an entry for Tramadol 50mg take one tablet every 12 hours as needed for pain.
-There was documentation of administration on 04/04/21 at 6:37am and 8:10pm.
-There was documentation of administration on 04/05/21 at 8:23pm, and on 04/06/21 at 8:12am.

Interview with Resident #3 on 04/15/21 at 1:02pm revealed:
-She was supposed to be receiving Tramadol for pain, but she ran out of the Tramadol last week and had not had any since.
-Her back hurt daily and she asked for Tramadol daily, but the staff just said, "it hasn't come in yet."

Observation of medications on hand for Resident #3 on 04/15/21 at 12:42pm revealed there was no Tramadol available for administration.

Interview with the Supervisor-in-Charge (SIC) on 04/15/21 at 12:42pm revealed:
-Resident #3 ran out of Tramadol on 04/06/21.
-She requested a refill the same day Resident #3 ran out of Tramadol (04/06/21) via the facility's eMAR system.
-The facility still had not received the medication.
-She had not contacted the pharmacy to inquire about why the Tramadol had not been received yet.
-She did not know if other staff had contacted the pharmacy to check on the status of the medication.

Telephone interview with the facility's contracted pharmacist on 04/16/21 at 11:24am revealed:
-Forty tablets of Tramadol 50mg were dispensed for Resident #3 on 03/04/21.
-The current order was for Tramadol one tablet to be administered every 12 hours as needed.
-Because Tramadol was a controlled medication,

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C 330	Continued From page 69 a new prescription was required from the physician before the medication could be refilled. -Staff at the facility requested the refill in the eMAR on 04/06/21. -On 04/06/21, when the refill was requested, the pharmacist submitted a new prescription request to the physician's office on that same day. Telephone interview with Resident #3's primary care provider (PCP) on 04/16/21 at 3:22pm revealed: -Resident #3's Tramadol was only to be administered as needed. -If Resident #3 began taking Tramadol more frequently, the Tramadol would run out and the resident would have to have an appointment with the PCP so she could evaluate why the resident needed the medication more often. -Once the resident attended the appointment and because the Tramadol was a controlled substance, she would evaluate the resident's need for the medication to decide if it needed to be changed to scheduled instead of as needed. -The PCP was not aware the resident had been out of Tramadol since 04/06/21 and the resident had been complaining of pain. -The resident had an appointment on 04/09/21 and there was no mention of the resident being out of Tramadol or that the resident was having any unrelieved pain at that appointment.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	C 342		

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C 342	Continued From page 70 (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, record reviews, and interviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia. Review of Resident #1's signed physician's order dated 03/18/21 revealed: -There was an order for finger stick blood sugar (FSBS) checks twice daily for two weeks then check once a day thereafter. -Resident #1's Hemoglobin A1c (a blood test that reflects a person's average blood glucose lever over the past 3 months. An A1c level of 5.7	C 342		

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percent or below is considered normal) was documented as 6.7%.

Review of Resident #1's signed physician's order dated 03/28/21 revealed:
-There was an order for FSBS checks twice daily scheduled at 8:00am and 8:00pm.
-There was an order for Lispro (an insulin injection used to treat diabetes) Sliding Scale Insulin (SSI) before meals as follows: Lispro less than (<) 150=0, 151-200=2 units, 201-250=6 units, 251-300=8 units, 301-350=10 units; greater than 351 call the primary care provider (PCP).
-At bedtime if FSBS is less than 200 do not give SSI dose, if greater than 200 give 50% of SSI dose.

Review of Resident #1's electronic Medication Administration Record (eMAR) for March 2021 revealed:
-There was an entry for FSBS checks scheduled at 8:00am and 8:00pm; there was a space designate to document the FSBS results.
-There was no documentation for FSBS on four out of 26 opportunities.
-There was documentation for FSBS that Resident #1 was out of the facility at 8:00am on 03/30/21 and 03/31/21; other mediation and temperature checks were documented as administered from on 03/30/21 and 03/31/21 at 8:00am.
-There was documentation FSBS checks were obtained on 03/30/21 and 03/31/21 at 5:00pm and 8:00pm.

Review of Resident #1's electronic medication Administration Record (eMAR) for April 2021 revealed:
-There was an entry for Lispro SSI to be administered at 8:00am and 8:00pm; there was a

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space designate to document the FSBS results and a space designated to document the Lispro units administered.
-The Administrator initials were documented on Resident #1's eMAR eight times next to the Lispro with the reason listed as "awaiting pharmacy medication order/physician prior authorization".
-There was documentation for FSBS and SSI results for 8 of 27 opportunities from 04/01/21, to 04/14/21.
-There was documentation Resident #1 was "awaiting pharmacy medication order/physician prior authorization" on 04/02/21, 04/03/21, and 04/04/21 at 8:00am and 04/02/21, 04/03/21, 04/04/21, 04/06/21, and 04/08/21 at 8:00pm; the Administrator's initials were document on each entry.

Observation of medication on hand on 04/15/21 at 9:03am revealed there were five Lispro 100 units pens in a refrigerator; the pens had a dispense date of 03/29/21.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 04/15/21 at 12:26pm revealed:
-Resident #1 had an order for FSBS twice a day dated 03/18/21 and an order for SSI dated 03/28/21.
-Five 3ml Lispro pens were dispensed on 03/29/21.

Interview with Resident #1 on 04/15/21 at 12:44pm revealed:
-She had seen the Administrator at the facility about a month ago and the Administrator stayed about an hour.
-The Administrator had administered her medication when she first came to the facility but

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C 342	Continued From page 73 she had not administered mediation in at least four months. Interview with a Supervisor-in-Charge (SIC) on 04/15/21 at 10:20am and 12:37pm revealed: -The Administrator did not work shifts for the staff. -The staff relieved each other when they needed the time off. -The Administrator did not administer medication. -The Administrator did not come to the facility very often; the last time was over two weeks ago. -There was a place to document the FSBS and the amount of insulin administered on the eMAR. -She also documented the FSBS on a log sheet. Interview with a second SIC on 04/15/21 at 4:45pm revealed: -She worked evenings and early mornings. -She had done FSBS for Resident #1 and documented them on the log sheet. Telephone interview with the facility's contracted Registered Nurse on 04/15/21 at 3:33pm revealed: -The Administrator did not administer medication, do FSBS or relieve staff when they were short. -The Administrator could sign on the eMAR remotely; she was not sure exactly what the Administrator could do but she had electronic authorization to access the eMAR. Interview with the Administrator on 04/15/21 at 1:4pm revealed the eMAR did not have "holes" on it. Interview with the Administrator on 04/15/21 at 7:13pm revealed: -She could document some notes remotely on the eMAR; she monitored "each and every" medication administration remotely.	C 342		

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C 342	Continued From page 74 -She explained the "awaiting pharmacy medication order/physician prior authorization" meant the medication was not at the facility and they were waiting for the pharmacy to deliver the medication. -The staff would tell her the medication was not at the facility and she could "key in the reason" remotely. -Medication usually only took a day to come from the pharmacy.	C 342		
C 353	10A NCAC 13G .1006(b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure a resident's insulin pens were maintained safely under locked security. The findings are: Observation a small refrigerator on 04/15/21 at 9:54am revealed: -There was a small refrigerator located in the residents dining room next to a water cooler accessible for resident use. -The refrigerator was not locked. -There was one insulin pen in a clear plastic bag and there were four insulin pens in a box inside	C 353		

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the refrigerator; the box was labeled with a sticker that read refrigerate.

Review of the daily progress notes for 03/29/21 revealed a resident's insulin pens came from the pharmacy and were put into the refrigerator next to the [water] cooler.

Interview with the Supervisor-in-Charge (SIC) on 04/15/21 at 9:45am revealed:
-The refrigerator had always been in the dining room.
-There had never been a lock on the refrigerator.
-The only medication stored in the refrigerator was a resident's insulin pens; "This is the insulin refrigerator".
-The resident had only been on the insulin for about a month.
-She did not know the medication needed to be locked and secured; no one had ever told her that.
-No one [residents] messed with the refrigerator.

Telephone interview with the Administrator on 04/14/21 at 2:33pm revealed:
-The small refrigerator in the dining room next to the water cooler was for residents' snacks.
-There should not be any medication stored in the refrigerator in the dining room.
-There was a locked box for storing medication in the refrigerator in the kitchen.
-She was not aware of any medication that needed to be stored under refrigeration.
-She did not know there were insulin pens that needed to be refrigerated.
-She did not instruct the staff about proper storage of the medication because they were medication aides and should know how to store medication under "lock and key".
-She had not been in the facility since 03/18/21

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C 353	Continued From page 76 and had not seen the medication in the unlocked refrigerator.	C 353		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure accident and incident reports were sent to the Department of Social Services (DSS) within 48 hours for 1 of 1 sampled resident (#1) who experienced a fall with an injury that required emergency medical treatment. The findings are: Review of Resident #1's current FL-2 dated 03/08/21 revealed: -Diagnoses included brain aneurysm, type 2 diabetes, umbilical hernia, obesity, schizophrenia, hypertension and hyperlipidemia. -Resident #1 was intermittently disoriented. Review of a progress note for Resident #1 dated 04/10/21 revealed:	C 444		

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C 444	Continued From page 77 -Resident #1 was found on the floor next to her bed on 04/10/2. -Emergency medical services (EMS) were called and responded Resident #1 was transported to the hospital for evaluation. -Resident #1 was kept in the hospital overnight and returned to the facility the next morning. Interview with the Adult Home Specialist with the local county DSS office on 04/14/21 at 8:30am revealed she had not received an Accident/Incident Report for Resident #1 for the fall that occurred on 04/10/21 with transport to the local hospital. Interview with the Supervisor-in-Charge (SIC) on 04/14/21 at 4:12pm revealed: -She notified the Administrator when Resident #1 would have a fall or when she called 911 for Resident #1. -She would call 911 when Resident #1 was hurt because she fell or when she fell because she was sick. -She did not always fill out an incident report when Resident #1 fell, but she documented it in the progress notes. -She would fill out an incident report when 911 was called. -She would fax the report to the Administrator and the Administrator would ask questions about the fall over the telephone. -She did not send the incident report to DSS. Telephone interview with the Administrator on 04/14/21 at 4:38pm revealed: -When Resident #1 had a fall with injuries, the staff called 911. -She did not consider Resident #1 as having a fall but a slide from the bed onto the floor most of the time she was found on the floor.	C 444		

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C 444	Continued From page 78 -Every time the EMS were called for a fall or incident, she submitted a report to the local county Department of Social Services (DSS). -She usually emailed the report to the Adult Home Specialist (AHS); she kept a confirmation of the email in her records. -The last time she had submitted a report to DSS was 04/09/21 when Resident #1 had a fall and was transport to the hospital by EMS. -Staff would notify her and she submitted the report to DSS. -She was aware she was supposed to send notification to DSS whenever residents were sent to the hospital for an injury. -Resident #1 did not always have an injury but would go to the hospital for evaluations.	C 444		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to outside entrances and exits, test for tuberculosis, other staff qualificiations, and adult care home medication aides training and competency evaluation requirements. The findings are:	C 912		

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C 912	Continued From page 79 1. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors had an alarm that was activated and sounded when the door was opened to alert staff for 1 of 1 residents (#1), who was known to wander into the community unsupervised. [Refer to tag C0069, 10A NCAC 13G. 0312(g) Outside Entrances and Exits. (Type B Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure 3 of 3 staff sampled (Staff A, B, C) were tested for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services upon hire. [Refer to tag C0140, 10A NCAC 13G. 0405(a) Test for Tuberculosis (Type B Violation)]. 3. Based on interviews, and record reviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, B, C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to tag C0145, 10A NCAC 13G. 0406(a)(5) Other Staff Qualifications (Type B Violation)]. 4. Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff, (Staff A, B, C), had a criminal background check completed upon hire.]Refer to tag C0147, 10A NCAC 13G. 0407(a)(7) Other Staff Qualifications (Type B Violation)]. 5. Based on interviews and record reviews, the facility failed to ensure 1 of 1 staff sampled who administered medications had completed a 5, 10 or 15 hour mandated medication aide training, completed their medication clinical skills competency validation prior to administering medications (Staff A, B, C), and successfully completed the required state examination (Staff	C 912		

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C 912	Continued From page 80 C). [Refer to tag C935, G.S. 131D-21 4.5B(b) Adult Care Home Medictation Aide Training and Competency (Continuing Unabataed Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure each resident was free of neglect related to management and other staff and personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules for family care homes related to outside entrances and exits, amedication administration, training on cardio-pulmonary resuscitation, test for tuberculosis, other staff qualifications, and adult care home medication aide training and competency evaluation requirements. [Refer to tag C0185, 10A NCAC 13G. 0601(a) Management and Other Staff (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with a resident's assessed needs, care plan and current symptoms for 1 of 3 sampled residents (#1) who was reported missing to local law enforcement and was known to go leave the facility unsupervised to go into the	C 914		

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	FCL093012	A. BUILDING: _____ B. WING _____	04/16/2021

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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
C 914	Continued From page 81 community seeking rides, food, money and cigarettes. [Refer to tag C0243, 10A NCAC 13G. 0901(b) Personal Care and Supervision (Type A2 Violation)].	C 914		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration.	C935		

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C935	Continued From page 82 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation has not been abated. Based on interviews and record reviews, the facility failed to ensure 1 of 1 staff sampled (Staff A) who administered medications had completed a 5, 10 or 15 hour mandated medication aide training and had a completed medication clinical skills competency validation prior to administering medications. The findings are: Review of the facility's personnel records revealed there was no record for Staff A, Supervisor-in-Charge (SIC) in the facility. Review of a resident's electronic Medication Administration Record (eMAR) from February 2021-April 2021 revealed: -Staff A documented administering oral medications and an inhaler to the resident on 15 occasions from 02/02/21-02/28/21. -Staff A documented administering oral medications and an inhaler to the resident on 18 occasions from 03/01/21-03/31/21. -Staff A documented administering oral	C935		

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C935	Continued From page 83 mediations and an inhaler to the resident on 7 occasions from 04/01/21-04/14/21. Review of a second resident's eMAR from March 2021 to April 2021 revealed Staff A documented obtaining finger stick blood sugar (FSBS) checks on 2 occasions from 03/26/21 to 04/08/21. Interview with Staff A on 04/14/21 at 9:00am revealed: -She had completed some training and signed off on paperwork. -She did not know specifically what paperwork she had signed. -She had been studying the medication aide (MA) handbook to take the MA exam. Second interview with Staff A on 04/14/21 at 12:50pm revealed: -She had been working at the facility a little over a month. -She began working between February and March 2021 (unsure of exact date). Interview with Staff A on 04/15/21 at 4:45pm revealed: -She worked evenings and early mornings. -She had obtained FSBS for Resident #1. -She had not had to administer Lispro to Resident #1 because her FSBS results were usually "good." Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -She was responsible for making the staff schedule and the Administrator was responsible for maintaining the personnel records. -She was looking for the personnel records a couple of weeks ago and all of them were not there.	C935		

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C935	Continued From page 84 -She did not know where all the personnel records were; there were some personnel records in a file cabinet in the medication office. Telephone interview with the Administrator on 04/14/21 at 5:00pm revealed: -The nurse with the faciliy's pharmacy completed the clinical skills checklist for Staff A. -All the personnel records were at the facility once but they had disappeared or been misplaced. -She had electronically scanned all the personnel records into her computer and could get copies for the survey team. -She thought the personnel records where filed in the office at the facility. -She was responsible for the personnel records. Documentation of Staff A's medication clinical skills checklist and 5-hour training certificate was requested on 04/14/21 at 5:00pm but was not provided by survey exit. _____ The facility failed to ensure Staff A, who administered medications were competency validated and completed the 5, 10, 15 hour mandated trainings prior to administering mediations, resulting in medication errors with insulin. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a continuing unabated Type B Violation. _____ The facility was provided a plan of protection in accordance with G.S. 131D-34 on 04/15/21 for this violation.	C935		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for	C992		

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C992	Continued From page 85 G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 3 of 3 sampled	C992		

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C992	Continued From page 86 staff (Staff A, and B) prior to hire. The findings are: 1. Review of the facility's personnel records revealed there was no record for Staff A, Supervisor-in-Charge (SIC) in the facility. Interview with Staff A on 04/14/21 at 12:50pm revealed: -She had been working at the facility a little over a month. -She began working between February and March 2021 (unsure of exact date). Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 2. Review of the facility's personnel records revealed there was no record for Staff B, Supervisor-in-Charge (SIC) in the facility. Telephone interview with Staff B on 04/16/21 at 11:56am revealed: -She trained with the SIC at the facility for four hours on Saturday, 04/10/21. -She worked on Monday 04/12/21 all day; she worked a half a day in the morning by herself and half of the day in the afternoon with the facility's contracted Registered Nurse (RN). Interview with a SIC on 04/15/21 at 5:36pm revealed: -Staff B just started working about a week or two ago. -Staff B was on the schedule to work this past Monday (04/12/21), but she did not work with	C992		

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C992	Continued From page 87 Staff B that day. Telephone interview with the facility's RN on 04/15/21 at 3:16pm revealed she had worked with Staff B on Monday, 04/12/21 for a most of the day. Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed Staff B was in the process of being trained; she had trained last Saturday, 04/10/21, with the SIC and worked with the facility's contracted RN on Monday (04/12/21). Telephone interview with the Administrator on 04/15/21 at 10:14am revealed: -Staff B had only trained half a day on Saturday, 04/10/21. -Staff B did not work on 04/10/21 but just "shadowed the SIC"; Staff B was not working at the facility "yet". Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. 3.Review of the facility's personnel records revealed there was no record for Staff C (Supervisor-in-Charge) in the facility. Interview with a SIC on 04/14/21 at 9:04am revealed Staff C worked part time on 2nd shift and weekends and relieved her on her days off. Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -Staff C had worked at the facility and then was off the schedule for a while, but the Administrator	C992		

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C992	Continued From page 88 had told her Staff C was cleared to return to work. -She had been told by the Administrator that it was "okay" for Staff C to work so she put Staff C on the schedule to work the upcoming weekend. -Staff C was on the staff schedule to work beginning at 5:00pm on Friday, 04/16/21, to Monday, 04/19/21, at 8:00am. Telephone interview with the Administrator on 04/15/21 at 9:45pm revealed: -Staff C used to work at the facility but she had been "let go" and did not work there anymore. -She did not know why someone would say Staff C still worked there because she "definitely does not work there". Attempted telephone interview with Staff C on 04/16/21 at 12:48pm was unsuccessful. Refer to the telephone interview with the facility's Business Manager on 04/15/21 at 11:05am. Refer to the telephone interview with the Administrator on 04/14/21 at 5:00pm. _____ Telephone interview with the facility's Business Manager on 04/15/21 at 11:05am revealed: -She was responsible for making the staff schedule and the Administrator was responsible for maintaining the personnel records. -She was looking for the personnel records a couple of weeks ago and all of them were not there. -She did not know where all the personnel records were; there were some personnel records in a file cabinet in the medication office. Telephone interview with the Administrator on 04/14/21 at 5:00pm revealed: -All the personnel records were at the facility once	C992		

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C992	Continued From page 89 but they had disappeared or been misplaced. -She had electronically scanned all the personnel records into her computer and could get copies for the survey team. -She thought the personnel records where filed in the office at the facility. -She was responsible for the personnel records. Documentation of staff drug screenings was requested on 04/14/21 at 5:00pm but was not provided by survey exit.	C992		