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THE HERITAGE OF SUGAR MOUNTAIN	264 SUGAR MOUNTAIN #2 ROAD NEWLAND, NC 28657

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and a complaint investigation on 05/03/21 to 05/04/21.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews the facility failed to ensure water temperatures were maintained between 100 and 116 degrees Fahrenheit (° F) as evidenced by water temperatures ranging from 72-130° F in 4 resident rooms, a common shower and a kitchen handwashing sink. The findings are: Observation of the water temperature in the bathroom sink adjoining bedroom #111 on 05/03/21 at 9:19am revealed the water temperature was 128° F and steam was visible. Observation of the water temperature in the bathroom sink between bedroom #110 and #108	D 113		

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on 05/03/21 at 9:29am revealed the water temperature was 128° F and steam was visible.

Observation of the water temperature in the bathroom sink in another resident's room on 05/03/21 at 10:10am revealed the water temperature was 126° F and steam was visible.

Observation of the water temperature in the beauty shop's shower on 05/03/21 at 10:15am revealed the water temperature was 128° F and steam was visible.

Observation of the water temperature in the bathroom sink adjoining bedroom #126 on 05/04/21 at 2:21pm revealed the water temperature was 72° F.

Interview with a resident residing in room #111 on 05/03/21 at 9:25am revealed:
-The water in her bathroom sink was "very hot".
-She had never been told the water was too hot nor had she burned herself with the water.

Interview with a personal care aide (PCA) on 05/03/21 at 9:29am revealed:
-The water was warm but not too hot.
-The water was warmer on one side of the hall because the water heater tank was on that side.

Interview with another resident residing in room #110 on 05/03/21 at 9:32am and 05/04/21 at 9:25am revealed:
-The water in her bathroom sink was "very hot".
-She knew how to mix the hot and cold water in her sink so she did not burn her hands.
-The water in the shower was hot also, but not as hot as the sink, and would burn her if she was not careful.
-She did not need help from staff to take a

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shower and knew how to adjust the shower's water temperature before she entered the shower in order to prevent burns.
-She had never mentioned the water temperatures to the Administrator.

Interview with a third resident residing in room #108 on 05/04/21 at 8:24am revealed:
-The sink water was very hot.
-He never told staff that the water was hot.
-"The other day" he forgot to turn on the cold water along with the hot water and he burned his hand "just a little bit".
-The hot water was not a problem as long as you remembered to use cold water along with the hot water.

Interview with a fourth resident on 05/04/21 at 9:04am revealed when the water in the beauty shop's shower was too hot he would adjust the temperature with the cold water.

Interview with a fifth resident on 05/04/21 at 9:06am revealed:
-The water in the beauty shop's shower was "super hot" but he knew to add cold water to adjust the temperature.
-He had not informed staff of the hot water.

Interview with a medication aide (MA) on 05/03/21 at 9:57am revealed:
-She had never noticed the water was too hot.
-The facility had 3 different water heaters to service different parts of the facility.

Interview with the Administrator on 05/03/21 at 10:58am revealed:
-She did not know that the water temperature was too hot until she was informed earlier in the day.
-She turned the water temperature down "just a

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bit ago".
-She did not check the water temperature routinely nor maintain a log.
-She did not have maintenance personnel on site.

Interview with another PCA on 05/04/21 at 8:23am revealed:
-The beauty shop/shower room in the old part of the building was the one used by residents who did not need assistance.
-When she helped residents with showers she "usually" used the shower on the new side of the building.
-Because of the washing machine, the water on the new side of the building was "usually too cold" and residents complained about it.
-She "occasionally" used the beauty shop's shower.
-Staff had to know how to adjust the water temperature, and as long as they did that the hot water was not a problem.
-If the water was too hot, the resident would tell her.

Observation of the water temperature in the bathroom sink between bedroom #110 and #108 on 05/04/21 at 8:39am revealed the water temperature was 130°F.

Observation of the water temperature in the kitchen's handwashing sink on 05/04/21 at 8:41am revealed the water temperature was 130°F.

Observation of the water temperature in the handwashing sink in the shower room on the new side of the building on 05/04/21 at 8:43am revealed the water temperature was 94°F.

Interview with the Administrator on 05/04/21 at

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D 113	Continued From page 4 8:45am revealed: -She was unaware the water temperature was hotter than the previous day. -She changed the water tank temperature dial yesterday. -She was unable to clearly see the dial so she was not sure if she adjusted it in the correct direction. -She would find some glasses and readjust the water tank dial. -She had a PCA help her yesterday. -She had not rechecked the water temperature since she adjusted the water tank dial. -She arranged for a local plumber to check the water tanks. -She would post a sign to caution residents and staff of hot water. Observation of the laundry room's water heater on 05/04/21 at 9:00am revealed: -The water heater was a double element water heater, with an adjustment dial located in both the upper and lower sections. -The temperature adjustment dials were adjustable from 90° F to 150° F. -There was a label on the outside of the tank warning of the dangers and risk of serious burns to adult skin with water temperatures above 120° F. -The label indicated water temperatures above 130° F produced serious burns in about 30 seconds, 140° F in less than 5 seconds, 150° F in about 1 1/2 seconds and 160° F in about 1/2 second. -The lower element was set to 95° F. -The upper element was set to 145° F. Observation of the boiler room in the basement of the facility on 05/04/21 at 9:15am revealed: -There were two water heater tanks located in the	D 113		

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room.
-One heater was labeled "kitchen" and the other heater was unlabeled.
-Both water heaters were double element water heaters, with an adjustment dial located in both the upper and the lower sections.
-The temperature adjustment dials were adjustable from 90° F to 150° F.
-The "kitchen" water heater's lower element was set to 150° F and the upper element was set to 125° F.
-The unlabeled water heater's lower element was set to approximately 100° F and the upper element was set to approximately 100° F.

Interview with a PCA on 05/04/21 from 8:51am to 9:15am revealed:
-Yesterday he helped the Administrator adjust the temperature on the laundry room's water heater.
-He adjusted the dial on the lower section of the water heater and did not realize until he was inspecting the tanks at 9:00am that there was a dial on the upper part of the water heater.
-He retested the sink's water temperature yesterday with a thermometer but he did not know what the temperature range should be, but it did not seem too hot.
-He did not remember where he obtained the thermometer nor remember what the temperature was.
-He had not retested the water temperature since he checked it yesterday.
-He had never adjusted the temperature on a water heater before.
-Maintenance staff was only in the building periodically.
-He was unaware there were other water heaters for the building.
-While inspecting the water heaters he adjusted the water temperature dials to approximately 120°

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D 113	Continued From page 6 F, until the plumber was able to inspect and adjust them. -He would check the water temperatures several times and continue to adjust the water heaters until the water temperature was between 100 and 116° F and he would maintain a log of the readings. _____ The facility failed to ensure hot water temperatures were maintained between 100 and 116°F which resulted in hot water temperatures ranging from 126-130°F in residents hand sinks and showers which can produce serious burns in 30 seconds. This failure resulted in risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131-D-34 on 05/03/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 03, 2021.	D 113		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by:	D 298		

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Based on observations, interviews, and record reviews, the facility failed to ensure food and beverages were offered or made available to all residents as snacks between each meal for a total of three snacks per day.

The findings are:

Review of the facility's weekly snack menu posted in the kitchen on 05/04/21 revealed:
-The menu, developed by a Registered Dietitian, listed food and beverage items to be served to the residents three times daily as snacks.
-The morning snack for each day of the week consisted of seasonal fruit and beverage.

Observations of the facility on 05/03/21 and 05/04/21 from 9:00am to 11:30pm revealed no food items were offered or made available to the residents as a snack.

Observation of the kitchen pantry on 05/04/21 at 10:32am revealed there was a 31 ounce box of cheese crackers and individual packaged graham crackers available for snacks.

Interviews with 8 residents during the initial tour on 05/03/21 from 9:00am to 10:30am revealed:
-The residents did not always receive a snack
-The facility did not always have snacks available.
-Snacks were offered two times daily and consisted of crackers or popcorn.
-Snacks were offered twice a day.
-Snacks were only offered at 2:00pm and 7:00pm.
-The facility staff provided snacks twice per day around 2:00pm and 8:00pm.
-Sometimes she only received juice for a snack.

Interview with a dietary aide on 05/03/21 at

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D 298	Continued From page 8 10:55am revealed: -The personal care aides (PCA) distributed beverages and snacks to residents. -The snacks consisted of a beverage at 10:00am and a beverage with food at both 2:00pm and 7:00pm. Interview with a PCA on 05/03/21 at 3:08pm revealed: -She distributed snacks at 10:00am and 2:00pm. -The 10:00am snack consisted of a beverage only but the 2:00pm snack consisted of a beverage and some type of cracker or cookie. -Second shift PCAs passed out the 7:00pm snack. -She did not know what they distibuted but she knew it was a beverage and food. Observation of snack distribution on 05/03/21 at 2:25pm revealed fish-shaped crackers and punch were given to residents. Interview with the Administrator on 05/04/21 at 10:02am revealed: -Snacks were offered to all residents twice daily. -The residents were only offered juice in the morning as a snack because that is what was written on the menu.	D 298		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care	D 317		

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exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of planned activities was provided each week for the residents.

The findings are:

Observation of the facility during the initial tour on 05/03/21 from 9:00am to 10:30am revealed:
-There was not an activity calendar posted in the facility.
-There were four board games on a table in a room at the end of the hall.

Interviews with 9 residents during the initial tour on 05/03/21 from 9:00am to 10:30am revealed:
-The facility offered bingo twice a week and handed out coloring books one time.
-There was not much to do but watch television.
-The facility offered bingo and they used to have crafts to do but that was "awhile ago".
-The Activity Director (AD) only came into the facility once every week or two.
-One resident would just stay in his room and watch television to keep himself occupied because he did not like bingo.
-A second resident did not like to play bingo.

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D 317	Continued From page 10 -A third resident did not like living at the facility because she was bored and never had anything to do. -The facility used to provide crafts "occasionally" but "not often". -A fourth resident watched television as her usual activity. -The AD played bingo with the residents. -A resident helped another resident make jewelry. Observation of the facility on 05/03/21 from 09:00am to 11:30am and 1:30pm to 5:00pm revealed: -Some residents walked in the halls. -Some residents sat in recliners or were lying on their beds with their eyes closed. -Some residents watched television in their rooms or in the living room. -No planned activities occurred. Observation of the facility on 05/04/21 from 7:30am to 11:00am and 1:00pm to 3:15pm revealed: -Some residents walked in the halls. -Some residents sat in recliners or were lying on their beds with their eyes closed. -Some residents watched television in their rooms or in the living room. -No planned activities occurred. Interview with a personal care aide (PCA) on 05/04/21 at 9:10am revealed: -The AD was responsible for all activities for residents. -The AD was only in the facility two times weekly. -The PCA did not know if there was an activity calendar or not. Interview with a second PCA on 05/04/21 at 9:14am revealed:	D 317		

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D 317	Continued From page 11 -There used to be an activity calendar posted on a bulletin board. -The AD had been on leave and recently returned. -The PCA did not know if anyone carried out activities with the residents during the AD's leave. Interview with the medication aide (MA) on 05/04/21 at 9:35am revealed: -The residents did not want to do any activity but play bingo. -The MA planned to take the residents outside more often when the weather was nice. Telephone interview with the AD on 05/04/21 at 9:50am revealed: -She had been on leave for 4 months. -She now worked 2 to 3 days per week in the facility. -The planned activity for the residents was bingo for one hour 2 to 3 times a week. Interview with the Administrator on 05/04/21 at 10:02am revealed: -The AD had just recently returned to work part time. -The facility did not have enough staff to conduct activities with the residents when the AD was not in the facility.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	D 338		

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D 338	Continued From page 12 TYPE B VIOLATION Based on record reviews and interviews, the facility failed to protect 1 of 3 sampled residents (Resident #1) from physical and mental abuse related to Staff B kicking a resident twice after an altercation, Staff B and another staff refusing to give the resident a snack and Staff B refusing to wash the resident's laundry (Resident #1). The findings are: Review of the facility's Resident Rights Policy revealed: -The resident was to be treated with respect, consideration, and dignity. -The resident was to receive care, and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. -The resident was to be free of mental and physical abuse and neglect. -The resident shall be given at least a thirty days' advance notice to ensure orderly transfer or discharge. -Staff B signed the Resident Rights on 02/09/18. Review of Resident #1's current FL2 dated 08/12/20 revealed: -Diagnoses included prolonged seizure activity, anxiety, major depression, chronic back pain, and hypertension. -Orientation was marked not applicable. -Inappropriate behaviors was marked not applicable. Review of Resident #1's Resident Register dated 02/15/19 revealed: -An admission date of 02/15/19. -Resident #1 was her own responsible person.	D 338		

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-The notice of discharge/transfer was documented as 04/27/21; initiated by the Administrator.
-Resident #1 was discharged on 04/27/21 to the local hospital and the reason was documented as "danger to staff and other residents".

Review of the Incident Report for Resident #1 dated 04/27/21 revealed:
-The date/time of the incident was documented as 04/27/21 at 2:45pm.
-Type of event was marked as "other" in the dining room.
-Resident #1's family member was notified of the incident documented as 04/27/21 at 2:45pm.
-Medical attention was not necessary.
-The physician was not notified.
-It was documented Resident #1 was not transported to the emergency room.
-The resident was not admitted to the hospital.
-It was documented "resident was checked by staff for injuries; none were found".

Review of the Incident Report for Staff B dated 04/27/21 revealed:
-The date/time of the incident was documented as 04/27/21 at 2:45pm.
-The incident occurred in the dining room and first aid was not required.
-The employee was checked for injuries, and there were scratches on her face, but medical attention was not required.

Review of the Progress Notes Report dated 09/01/20 through 05/03/21 revealed:
-On 04/27/21, there was no documentation of the altercation between Resident #1 and Staff B.
-On 04/28/21, there was documentation Resident #1 was discharged.

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Review of the facility's annual competency on 05/03/21 revealed Staff B had completed resident rights training on 03/19/19.

Review of the 24-Hour Initial Report for the Health Care Personnel Registry (HCPR) undated revealed:
-Incident date was documented as 04/27/21 at 2:45pm.
-Staff B's title was documented as personal care aide (PCA) and was the accused individual.
-Resident #1's name was documented for the resident information.
-The allegation description was documented as "employee was sitting in the dining room eating before her shift started and the resident approached her attacking about the head and neck with her fist: in return the employee was defending herself and accidentally hit the resident".
-Allegation/incident type was not marked.
-The incident was reported to the local county sheriff's department.
-Date reported was documented as 04/28/21 at 2:45pm.
-The allegation was not substantiated by the Administrator with an investigation end date of 05/01/21.
-There was a medication aide (MA) and PCA documented as 2 witnesses.

Review of the 5-Working Day Report dated 05/03/21 revealed:
-The 24-hour Initial report was documented as submitted to the HCPR on 04/29/21 by fax.
-The allegation/incident type was not marked.
-The incident description was documented as "employee was sitting in the dining room resident approached her, attacking her and shoving her chair trying to push it out the window and hitting

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her."
-"The employee raised her hands to protect herself and accidentally struck the resident."
-Staff B was documented as the accused individual.

Interview with the first shift PCA on 05/03/21 at 1:58pm revealed:
-He worked on 04/27/21 and heard screaming in the dining room and found Resident #1 on top of Staff B and he pulled the two apart and escorted Resident #1 outside to smoke.
-He did not see Resident #1 hit Staff B.
-Resident #1 was never violent with any other staff or residents.
-Staff B and Resident #1 did not "get along".

Interview with a first shift MA on 05/03/21 at 2:06pm revealed:
-She worked on 04/27/21 and heard "hollering" in the dining room and found Staff B laying over the chair and Resident #1 was leaned over top of Staff B.
-She pulled Resident #1's pants and she moved away from Staff B.
-She called the local county sheriff's office to respond to the altercation.
-She called Resident #1's family member and informed her of the altercation and requested she come to the facility.
-She called the Administrator but could not get her on the telephone, so she notified the Owner of the facility.
-Resident #1's family member took Resident #1 to the local hospital to be evaluated.
-The facility's policy for an altercation between staff and residents was to notify the Administrator and fill out an incident report.
-She did not fill out an incident report she had "50 other things going on".

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-She thought she had documented the incident of the altercation in the Progress Notes Report in the computer system, but she could not find the documentation.

Interview with Staff B on 05/03/21 at 2:30pm revealed:
-She had reported to the Administrator Resident #1 had gotten "more hateful" towards her and the Administrator told her to "try to stay away from her" (Resident #1).
-She never went into Resident #1's room alone and was always accompanied by the second shift MA.
-Resident #1 did not like her or the second shift MA.
-On 04/27/21, she was eating in the dining room when Resident #1 came in and pushed her chair over while Resident #1 "punched my body, she couldn't reach my face to scratch it like she's done to other people".
-She screamed for other staff to assist getting Resident #1 off her.
-The police officer was "angry at me and said I hit her in the face" (Resident #1).
-She did not hit or kick Resident #1.
-She was trained by the facility's contracted nurse on resident rights.
-She documented the incident of the altercation with Resident #1 on 04/27/21 on a piece of paper on 05/02/21.
-She was not suspended from working at the facility while the Administrator performed the 5-Working Day investigation.

Interview with the second shift MA on 05/03/21 at 2:42pm revealed:
-She did not work on 04/27/21 when Resident #1 and Staff B got into an altercation.
-She had "trouble" with Resident #1 "all the time".

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-Recently she and Staff B passed out cookies for a snack to the residents and Resident #1 yelled down the hallway that they had not offered her a snack and for her and Staff B to give her a snack.
-She told Resident #1 "no ma'am, you need to go in your room and calm down".
-Resident #1 went back inside of her room.

Telephone interview with the sheriff's deputy on 05/04/21 at 7:48am revealed:
-He responded to a call made by the facility on 04/27/21 involving Resident #1 assaulting Staff B.
-Resident #1 was outside smoking a cigarette accompanied by the first shift PCA when he arrived.
-The first shift PCA reported to him that he saw Staff B kick Resident #1 twice after the altercation.
-Staff B was in the office with the first shift MA and said, "I really got her didn't I" and was smiling at the first shift MA.
-He accompanied Resident #1 into the office and Staff B leaned out of her chair and said to Resident #1 "you're going to jail (expletive)".
-He heard Staff B say, "next time I'll just shoot" to Resident #1.
-Resident #1 reported to him Staff B rammed her chair into Resident #1's legs and that was why she pushed Staff B's chair over.
-He spoke with the Administrator regarding the altercation and left the facility.
-He had everything Staff B and the second shift PCA said recorded on his body camera.

Interview with the first shift MA on 05/04/21 at 8:30am revealed she did not know if Staff B kicked Resident #1, but she heard Staff B say, "she really got her" and then she called Resident #1 a (expletive).

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D 338	Continued From page 18 Interview with the first shift PCA on 05/04/21 at 8:34am revealed: -On 04/27/21, after Resident #1 was moved from leaning over Staff B, "it looked like" Staff B kicked Resident #1 twice. -He did not know if Staff B had kicked Resident #1 on purpose, "she said her foot slipped". -He was "more concerned" for Resident #1 "than anything". -Resident #1 told him Staff B hit her in the legs with a chair repeatedly and that was when she knocked Staff B's chair over. -He only saw Resident #1 leaned over Staff B and did not see Resident #1 hit Staff B. Interview with the Administrator on 05/04/21 at 8:48am revealed: -She was not at the facility when Resident #1 and Staff B got into an altercation. -Resident #1 "slammed the chair against the window" knocking Staff B over for no reason. -Resident #1 antagonized Staff B and had been "dogging" her for a long time. -Resident #1 took her laundry to Staff B at 9:00pm or 10:00pm and wanted it done by shift change. -Resident #1 said staff had put a dead fly on her hamburger and would not eat the facility's meals for 4 days. -All residents were provided snacks and she did not know Staff B and the second shift MA refused to give Resident #1 a snack. -She contacted Resident #1's physician a week before the altercation about Resident #1's behavioral issues and "meds didn't do any good for that crazy woman". -She did not give Resident #1 a 30-day notice for discharge. -She did not know if Staff B hit or kicked Resident #1 "trying to get away".	D 338		

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-She faxed the 24-hour report to the HCPR 48 hours after the incident on 04/29/21 because the fax machine was not working.
-All incidents with residents were documented in the Progress Notes Report section in the computer and she did not know why the first shift MA did not document the altercation between Staff B and Resident #1.
-The facility's policy for resident abuse included to abide by resident rights, notify the local county Department of Social Services (DSS), fill out a 24-hour report and fax it to the HCPR, complete an investigation of the incident and fill out a 5 working day report.
-She would not let staff work in the facility that had abused any of the residents.
-Staff B was still allowed to work while she conducted the 5 working day investigation because Resident #1 was discharged from the facility and Staff B was not a threat to the other residents residing at the facility.
-She expected staff to adhere to the Resident Rights policy.

Telephone interview with Resident #1's Primary Care Provider on 05/04/21 at 9:59am revealed:
-Resident #1 had become more "withdrawn" and got "a little hateful" over the last 3 to 4 months.
-Resident #1 had "issues" with some of the facility staff.
-Resident #1 was not seen by a mental health provider.
-She thought there was "more going on than what I am aware of" between Resident #1 and some of the facility staff.
-She thought something had happened between staff and Resident #1 to "trigger her change" and cause the altercation.
-Resident #1 had never been rude or disrespectful towards her and was always honest

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with her.
-The altercation between Resident #1 and Staff B "floored me".

Telephone interview with a representative at HCPR on 05/04/21 at 10:09am revealed:
-HCPR received a fax of the 24-Hour Initial Report from the facility on 04/29/21 at 4:53pm.
-A copy of the 5-Working Day Report from the facility had not yet been received.

Interview with the cook on 05/04/21 at 10:41am revealed:
-He had only worked for the facility about 2 weeks, but he had observed Resident #1 and Staff B did not "get along".
-He worked on 04/27/21 when Staff B and Resident #1 got into an altercation.
-He heard "hollering" in the dining room and saw Staff B lying in the corner with Resident #1 holding her down.
-Resident #1 did not hit Staff B.
-He did not know what started the altercation between Staff B and Resident #1.
-He heard Staff B tell Resident #1 she was going to rot in jail and he and another staff member separated the two and escorted them to different areas.
-Resident #1 had told him previously that she did not get along with Staff B.
-He had "no trouble" with Resident #1.

Telephone interview with Resident #1's family member on 05/04/21 at 11:45am revealed:
-The first shift MA called her on 04/27/21 and told her Resident #1 had been in an altercation with Staff B and to come get Resident #1 and take her to the hospital or she would be taken to jail.
-Resident #1 said she had gone into the dining room to see what the kitchen staff were fixing for

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dinner when Staff B said something mean to her.
-Resident #1 walked over to where Staff B was sitting and that was when she hit her in the legs with the chair.
-Resident #1 told her Staff B had rammed a chair into her legs on purpose and she pushed Staff B's chair knocking her over.
-A staff member told her when she arrived at the facility that Staff B had hit Resident #1 with a chair and kicked her.
-Resident #1 had "places" on her knee and her leg was "really red" when she had picked Resident #1 up from the facility.
-Resident #1 had never been in an altercation before.
-Resident #1 did not like the second shift MA or Staff B because she said they were "mean to her".
-Resident #1 had called her several times in the past crying because of the way Staff B and the second shift MA had treated her.
-The last time Resident #1 called her crying about how staff treated her was when Staff B and the second shift MA refused to give her a snack while they passed the snacks out to the other residents.
-Another incident when Resident #1 called her crying was when Staff B refused to wash her laundry and it was supposed to have been washed.
-Resident #1 was still in the hospital because she was discharged by the facility and the hospital had not found another facility for her to reside.

Interview with Staff B on 05/04/21 at 2:35pm revealed:
-She did not tell the first shift MA on 04/27/21 that she "got a couple of extra hits in" but she was upset and "it is hard to tell" if she said that or not.
-"I don't know if I said it out loud that I would shoot her" (Resident #1).

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D 338	Continued From page 22 -Resident #1 never "took our snacks" so her and the second shift MA did not offer snacks to Resident #1 until she "got mad about it". -She kicked Resident #1 to "save myself" and get her legs off of the chair. -When asked again if she had kicked Resident #1, she said, "how else was I supposed to respond" to Resident #1 pushing her over in the chair and get Resident #1 off her legs. -She had to kick Resident #1 in order to "save herself". _____ The facility failed to protect Resident #1 from physical and mental abuse related to Staff B kicking Resident #1 twice during an altercation, Staff B and another staff refusing to give Resident #1 a snack and Staff B refusing to wash Resident #1's laundry. The facility's failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 on 05/04/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 18, 2021.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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D 438	Continued From page 23 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to protect the residents from harm by allowing Staff B to continue to work during an active investigation of alleged abuse. The findings are: Review of Resident #1's current FL2 dated 08/12/20 revealed: -Diagnoses included prolonged seizure activity, anxiety, major depression, chronic back pain, and hypertension. -Orientation was marked not applicable. -Inappropriate behaviors was marked not applicable. Review of Resident #1's Resident Register dated 02/15/19 revealed: -An admission date of 02/15/19. -Resident #1 was her own responsible person. -The notice of discharge/transfer was documented as 04/27/21 initiated by the Administrator. -Resident #1 was discharged on 04/27/21 to the local hospital and the reason was documented as "danger to staff and other residents". Review of the Incident Report for Resident #1 dated 04/27/21 revealed: -The date/time of the incident was documented as 04/27/21 at 2:45pm. -Type of event was marked as "other" in the dining room. -Resident #1's family member was notified of the incident documented as 04/27/21 at 2:45pm. -Medical attention was not necessary. -The physician was not notified.	D 438		

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-It was documented Resident #1 was not transported to the emergency room.
-The resident was not admitted to the hospital.
-It was documented "resident was checked by staff for injuries; none were found".

Review of the Incident Report for Staff B dated 04/27/21 revealed:
-The date/time of the incident was documented as 04/27/21 at 2:45pm.
-The incident occurred in the dining room and first aid was not required.
-The employee was checked for injuries, and there were scratches on her face, but medical attention was not required.
Review of the Care Notes Report dated 09/01/20 through 05/03/21 revealed:
-On 04/27/21, there was no documentation of the altercation between Resident #1 and Staff B.
-On 04/28/21, there was documentation Resident #1 was discharged.

Review of the staffing schedule for Staff B revealed she worked 3:00pm to 11:00pm on 04/27/21 through 04/28/21, 05/01/21 through 05/03/21, and was scheduled to work 3:00pm to 11:00pm 05/04/21.

Review of the 24-Hour Initial Report for the Health Care Personnel Registry (HCPR) undated revealed:
-Incident date was documented as 04/27/21 at 2:45pm.
-Staff B's title was documented as personal care aide (PCA) and was the accused individual.
-Resident #1's name was documented for the resident information.
-The allegation description was documented as "employee was sitting in the dining room eating before her shift started and the resident

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approached her attacking about the head and neck with her fist: in return the employee was defending herself and accidentally hit the resident".
-Allegation/incident type was not marked.
-The incident was reported to the local county sheriff's department.
-Date reported was documented as 04/28/21 at 2:45pm.
-The allegation was not substantiated by the Administrator with an investigation end date of 05/01/21.
-There was a medication aide (MA) and PCA documented as 2 witnesses.

Review of the 5-Working Day Report dated 05/03/21 revealed:
-The 24-hour Initial report was documented as submitted to the HCPR on 04/29/21 by fax.
-The allegation/incident type was not marked.
-The incident description was documented as "employee was sitting in the dining room resident approached her, attacking her and shoving her chair trying to push it out the window and hitting her."
-"The employee raised her hands to protect herself and accidentally struck the resident."
-Staff B was documented as the accused individual.

Interview with Staff B on 05/03/21 at 2:30pm revealed:
-She had reported to the Administrator Resident #1 had gotten "more hateful" towards her and the Administrator told her to "try to stay away from her" (Resident #1).
-She never went into Resident #1's room alone and was always accompanied by the second shift MA.
-Resident #1 did not like her or the second shift

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MA.
-On 04/27/21, she was eating in the dining room when Resident #1 came in and pushed her chair over while Resident #1 "punched my body, she couldn't reach my face to scratch it like she's done to other people".
-She screamed for other staff to assist getting Resident #1 off her.
-The police officer was "angry at me and said I hit her in the face" (Resident #1).
-She did not hit or kick Resident #1.
-She was not suspended from working at the facility while the Administrator performed the 5-Working Day investigation.

Telephone interview with the sheriff's deputy on 05/04/21 at 7:48am revealed:
-He responded to a call made by the facility on 04/27/21 involving Resident #1 assaulting Staff B.
-Resident #1 was outside smoking a cigarette accompanied by the first shift PCA when he arrived.
-The first shift PCA reported to him that he saw Staff B kick Resident #1 twice after the altercation.
-Staff B was in the office with the first shift MA and said, "I really got her didn't I" and was smiling at the first shift MA.
-He accompanied Resident #1 into the office and Staff B leaned out of her chair and said to Resident #1 "you're going to jail expletive".
-He heard Staff B say, "next time I'll just shoot" to Resident #1.
-Resident #1 reported to him Staff B rammed her chair into Resident #1's legs and that was why she pushed Staff B's chair over.

Interview with the first shift MA on 05/04/21 at 8:30am revealed she did not know if Staff B kicked Resident #1, but she heard Staff B say,

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	HAL006005	A. BUILDING: _____ B. WING _____	R 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HERITAGE OF SUGAR MOUNTAIN	264 SUGAR MOUNTAIN #2 ROAD NEWLAND, NC 28657

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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"she really got her" and then she called Resident #1 a (expletive).

Interview with the first shift PCA on 05/04/21 at 8:34am revealed:
-On 04/27/21, after Resident #1 was moved from leaning over Staff B, "it looked like" Staff B kicked Resident #1 twice.
-He did not know if Staff B had kicked Resident #1 on purpose, "she said her foot slipped".
-He was "more concerned" for Resident #1 "than anything".
-Resident #1 told him Staff B hit her in the legs with a chair and that was when she knocked Staff B's chair over.
-He only saw Resident #1 leaned over Staff B and did not see Resident #1 hit Staff B.

Interview with the Administrator on 05/04/21 at 8:48am revealed:
-She was not at the facility when Resident #1 and Staff B got into an altercation.
-Resident #1 "slammed the chair against the window" knocking Staff B over for no reason.
-Resident #1 antagonized Staff B and had been "dogging" her for a long time.
-She did not know if Staff B hit or kicked Resident #1 "trying to get away".
-She faxed the 24-hour report to the HCPR 48 hours after the incident on 04/29/21 because the fax machine was not working.
-Staff B was still allowed to work while she conducted the 5 working day investigation because Resident #1 was discharged from the facility and she did not think Staff B was a threat to the other residents residing at the facility.
-Her investigation included interviewing the facility staff and obtaining written documentation from the staff who witnessed the altercation between Staff B and Resident #1.

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-The facility's policy for resident abuse included to abide by resident rights, notify the local county Department of Social Services (DSS), fill out a 24-hour report and fax it to the HCPR, complete an investigation of the incident and fill out a 5 working day report.

Telephone interview with a representative at HCPR on 05/04/21 at 10:09am revealed:
-HCPR received a fax of the 24-Hour Initial Report from the facility on 04/29/21 at 4:53pm.
-A copy of the 5-Working Day Report from the facility had not yet been received.

Interview with the cook on 05/04/21 at 10:41am revealed:
-He had only worked for the facility about 2 weeks, but he had observed Resident #1 and Staff B did not "get along".
-He worked on 04/27/21 when Staff B and Resident #1 got into an altercation.
-He heard "hollering" in the dining room and saw Staff B lying in the corner with Resident #1 holding her down.
-Resident #1 did not hit Staff B.
-He did not know what started the altercation between Staff B and Resident #1.
-He heard Staff B tell Resident #1 she was "going to rot in jail" and he and another staff member separated the two and escorted them to different areas.
-Resident #1 had told him previously that she did not get along with Staff B.
-He had "no trouble" with Resident #1.

Telephone interview with Resident #1's family member on 05/04/21 at 11:45am revealed:
-The first shift MA called her on 04/27/21 and told her Resident #1 had been in an altercation with Staff B and to come get Resident #1 and take her

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to the hospital or she would be taken to jail.
-Resident #1 said she had gone into the dining room to see what the kitchen staff were fixing for dinner when Staff B said something mean to her.
-Resident #1 walked over to where Staff B was sitting and that was when she hit her in the legs with the chair.
-Resident #1 told her Staff B had rammed a chair into her legs on purpose and she pushed Staff B's chair knocking her over.
-A staff member told her when she arrived at the facility to pick up Resident #1 that Staff B had hit Resident #1 with a chair and kicked her.
-Resident #1 had "places" on her knee and her leg was "really red" when she had picked Resident #1 up from the facility.
-Resident #1 had never been in an altercation before.
-Resident #1 had called her several times in the past crying because of the way Staff B had treated her.

Interview with Staff B on 05/04/21 at 2:35pm revealed:
-She did not tell the first shift MA on 04/27/21 that she "got a couple of extra hits in" but she was upset and "it is hard to tell" if she said that or not.
-"I don't know if I said it out loud that I would shoot her" (Resident #1).
-She kicked Resident #1 to "save myself" and get her legs off of the chair.
-When asked again if she had kicked Resident #1, she said, "how else was I supposed to respond" to Resident #1 pushing her over in the chair and get Resident #1 off her legs.

_____

The facility failed to protect the residents from harm by allowing Staff B to continue to work during an active investigation of alleged abuse. The failure of the facility was detrimental to the

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D 438	Continued From page 30 safety and welfare of all residents and constitutes a Type B violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/04/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 18, 2021.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services relevant to federal and state laws and rules and regulations related to other requirements and health care personnel registry. The findings are: A. Based on observations and interviews the facility failed to ensure water temperatures were maintained between 100 and 116 degrees Fahrenheit (° F) as evidenced by water temperatures ranging from 72-130° F in 4 resident rooms, a common shower and a kitchen handwashing sink. [Refer to Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type A2 Violation)].	D912		

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D912	Continued From page 31 B. Based on record reviews and interviews, the facility failed to protect the residents from harm by allowing Staff B to continue to work during an active investigation of alleged abuse. [Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all residents were free from physical and mental abuse related to resident rights. The findings are: Based on record reviews and interviews, the facility failed to protect 1 of 3 sampled residents (Resident #1) from physical and mental abuse related to Staff B kicking a resident twice after an altercation, Staff B and another staff refusing to give the resident a snack and Staff B refusing to wash the resident's laundry (Resident #1). [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		