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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE ASSISTED LIVING	2140 MILTON ROAD CHARLOTTE, NC 28205

(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 survey and complaint investigation on 06/21/21-06/23/21.	D 000		
D 230	10A NCAC 13F .0702 (f) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) notifying staff in the county department of social services responsible for placement services; (2) explaining to the resident and responsible person or legal representative why the discharge is necessary; (3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and (4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2; (B) a copy of the resident's most current assessment and care plan; (C) a copy of the resident's current physician orders; (D) a list of the resident's current medications; (E) the resident's current medications; (F) a record of the resident's vaccinations and TB screening; (5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule: (A) the regional long term care ombudsman; and	D 230		

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D 230	Continued From page 1 (B) the protection and advocacy agency established under federal law for persons with disabilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to provide an orderly discharge for 1 of 1 sampled resident (Resident #2) who was discharged to a local hospital. The findings are: Review of Resident #2's current FL2 dated 06/02/21 revealed: -Diagnoses included Alzheimer's dementia, bipolar disorder, Parkinson's disease and schizoaffective disorder. -The level of care was Special Care Unit (SCU). Review of Resident #2's Resident Register revealed: -Resident #2 was admitted on 11/25/19. -The resident was discharged on 06/04/21 to the hospital. Review of Resident #2's psychiatric visit note dated 06/01/21 revealed: There was a note from Resident #2's psychiatrist on 06/01/21 documenting the facility was unable to meet the resident's psychiatric needs and required placement in an environment equipped with medical staff accustomed to treating severe mental illness. Review of Resident #2's progress notes revealed: -Resident #2 had been sent to the hospital for aggressive/agitated incidents 4 times from 02/03/21-05/17/21.	D 230		

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D 230	Continued From page 2 -Review of Resident #2's progress notes revealed there was no planning for a safe and orderly discharge. Review of Resident #2's discharge notice revealed: -There was a discharge notice was dated 06/04/21. -The was no date of discharge documented. -The discharge reason indicated was "the health of the resident or other individuals in the facility is endangered as documented by physician, physician assistant, or nurse practitioner". -The discharge location was hospital. Review of Resident #2'sphysician's orders revealed there was no FL2 indicating a hospital level of care. Interview with Resident #2's healthcare power of attorney (HPOA) on 06/21/21 at 2:25pm revealed: -He found out of about the immediate discharge on 06/07/21 after the hospital Social Worker called him. -The facility told him that they left a message for him, but he never received a voice message. -He received a certified letter in the mail after the discharge occurred. -He had not spoken to anyone at the facility regarding another placement for Resident #2 since the resident lived at the facility. -He was familiar with Resident #2's psychiatric history, however he did not know another placement was needed to keep Resident #2 safe. Interview with the local hospital Behavioral Health Social Worker on 06/21/21 at 12:10pm revealed: -Resident #2 was brought to the behavioral health unit of the hospital on 06/04/21 after a petition was filed for aggressive behavior.	D 230		

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-After the resident was sent to behavioral health, she attempted to contact the facility Administrator to gather additional information and she could not be reached until 06/07/21.
-On 06/07/21, she spoke with the Administrator, she informed shhe discharged Resident #2 to the hospital.
-On 06/07/21, the Administrator informed she issued a discharge notice which she reviewed with Resident #2, even though he was diagnosed with dementia and was experiencing agitation and aggressive behaviors.
-Since being admitted to the hospital, the resident had not displayed aggressive behaviors.
-Resident #2 was not appropriate to remain in the behavioral health unit of the hospital.
-Resident #2 remained in the psychiatric observation unit while a team of Social Workers were seeking to find placement in an assisted living facility.
-They did not have a plan for Resident #2's discharge and no place for him to reside.
-The resident had been in the observation unit for 18 days with nowhere to go.

Interview with the local hospital Psychiatrist on 06/22/21 at 11:32am revealed:
-Resident #2 would be appropriate to reside in a supervised assisted living facility.
-The hospital behavioral health unit held individuals in a psychological observation to monitor for 24-48 hours before they were admitted.
-Resident #2 did not meet the criteria to be admitted to the psychiatric unit of the hospital.
-The hospital did not have a placement for Resident #2.
-At the hospital, Resident #2 was around other individuals with a high degree of acute mental health issues such as suicidal ideations and

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hallucinations.
-Staying in the observation unit placed Resident #2 at risk for others to be aggressive towards him due to his dementia; at times Resident #2 would go into other patient's space which caused other patients to get upset.
-Further stay in the psychiatric observation unit placed Resident #2 at risk for an advancement of his current mental health issues.
-Resident #2's level of care was assisted living.

Interview with Resident #2's primary care provider (PCP) on 06/22/21 at 9:55am revealed:
-He was familiar with Resident #2's mental health issues related to aggression and agitation.
-He referred the resident to a mental health provider for further treatment.
-He never completed an FL2 indicating Resident #2 was hospital level of care.

Interview with Resident #2's mental health provider on 06/22/21 at 3:39pm revealed:
-She was Resident #2's mental health provider while he resided at the facility.
-She wrote the note on 06/01/21 indicating Resident #2 needed placement in an environment equipped with medical staff accustomed to treating severe mental illness.
-On 05/03/21, she recommended Resident #2 be sent to a secured residential treatment center in another county.
-She never filled out an FL2 or sent any information about Resident #2 to another facility for placement.

Interview with the Ombudsman on 06/22/21 at 3:29pm revealed:
-She never received a call from the facility regarding an appropriate discharge for Resident #2.

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D 230	Continued From page 5 -She helped facilities with appropriate discharges when needed. -She would assist the facility with an action plan, follow-up with physician and family to achieve an appropriate and orderly discharge if asked. Interview with the local county Adult Home Specialist (AHS) on 06/23/21 at 10:10am revealed: -She never received a call from the facility regarding Resident #2's discharge. -If she was contacted, she would have assistedd the facility with initiating a safe an orderly discharge for Resident #2. Interview with the Administrator on 06/22/21 at 2:30pm revealed: -She discharged Resident #2 on 06/04/21 after retrieving a petition for involuntary commitment. -On 06/04/21, Resident #2 became agitated, yelling and cursing, the police came and took him to the hospital. -She completed the discharge notice and discharged the resident to the hospital due to his aggressive behaviors. -She had the resident sign the discharge notice and left the family member a voice message. -She thought it was appropriate for the resident to sign the discharge notice. -In the past, she tried to get Resident #2 placed at a mental health treatment center, however they would not take the resident because he was in the hospital. -She never reached out to the local Ombudsman or county AHS for guidance regarding an appropriate discharge for Resident #2 on 06/04/21. -She thought sending Resident #2 to the hospital behavioral health unit was an appropriate discharge.	D 230		

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D 230	Continued From page 6 The facility failed to provide a safe and orderly discharge for Resident #2 by not coordinating an appropriate placement of discharge for the resident, which resulted in the resident residing in the behavioral health hospital's observations unit for 18 days without an appropriate placement resulting in Resident #2 at risk for increased mental health complications. This failure was detrimental to the health, safety and well-being which constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on June 22, 2021. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	D 230		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult 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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff assisted 3 of 5 sampled residents (#1, #4, & #5) including staff not providing catheter care (#1), and for two	D 269		

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residents who required extensive assistance with bathing and dressing (#4 & #5).

The findings are:

1. Review of Resident #1's current FL2 dated 04/09/21 revealed:
-He was admitted to the facility on 04/01/19.
-Diagnoses included seizure disorder, chronic obstructive pulmonary disease and urinary retention.

Review of Resident #1's hospital discharge summary dated 10/12/20 revealed:
-Resident #1 presented to the Emergency Department (ED) as continent but unable to void.
-He had an indwelling Foley catheter placed and was discharged to the facility with the catheter and to be followed by a urologist.

Review of a physician's order dated 02/16/21 revealed:
-There was an order for Home Health (HH) to manage Resident #1's Foley catheter.
-Staff were to clean the tubing twice a day with warm soapy water, from the head of the penis to the end of the catheter tube.

Telephone interview with Resident #1's primary care physician (PCP) on 06/22/21 at 9:50am revealed:
-Resident #1 returned from a hospital visit last October 2020 with a Foley catheter due to an inability to void.
-The facility staff were managing the Foley catheter between October 2020 and February 2021.
-The staff were to clean the site and looking for intactness of the catheter.
-Resident #1 was non compliant with his care and

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was refusing to allow the staff to manage his Foley care.
-Due to this non compliance with care, he wrote an order dated 02/16/21 for Home Health (HH) to manage Resident #1's catheter.
-Staff were to clean the catheter tubing twice a day with warm soapy water from the head of penis to the end of the catheter tube.

Interview with HH Office Coordinator on 06/22/21 at 12:53pm revealed:
-HH received an order from Resident #1's PCP on 02/16/21 to provide monthly visits for the care of Resident #1's indwelling Foley catheter.
-Resident #1 received HH services from 02/18/21 through 06/16/21.
-The HH RN educated the resident on proper catheter care since staff reported he was independent with catheter care.
-Staff were not educated on catheter care by the HH RN.

Interview with the Memory Care Manager (MCM) on 06/22/21 at 1:45pm and 06/23/21 at 1:35pm revealed:
-She was not aware Resident #1 had a Foley catheter between December 2020 and February 2021.
-The catheter was removed before the urologist visit on 12/15/21, and she did not know it was replaced at the visit.
-She requested an order from the PCP on 02/16/21 for HH to manage the catheter and staff to have directions for personal care.
-The staff reported Resident #1 took care of his own catheter, emptying the urine from the bag and cleaning the site.
-She entered the order from the PCP for staff to clean the catheter tubing twice a day with warm soapy water, from the head of the penis to the

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end of the catheter tube on Resident #1's electronic medication administration record (eMAR).

Review of Resident #1's April 2021 eMAR revealed:
-There was an entry from 04/07/21 through 04/30/21, special instructions, clean catheter with warm soapy water from the head of the penis to the end of the Foley tube twice daily, between 7:00am-3:00pm and 3:00pm-11:00pm. Empty urine from the Foley bag and document the amount.
-There was documentation from 04/07/21 through 04/16/21 and 04/19/21 through 04/30/21 Resident #1's catheter was cleaned with warm soapy water twice daily and the urine amount recorded.
-There was documentation Resident #1 refused catheter care on 04/17/21 and 04/18/21.

Review of Resident #1's May 2021 eMAR from 05/01/21 through 05/28/21 revealed:
-There was an entry from 05/01/21 through 05/28/21, special instructions, clean catheter with warm soapy water from the head of the penis to the end of the Foley tube twice daily, between 7:00am-3:00pm and 3:00pm-11:00pm.. Empty urine from the Foley bag and document the amount.
-There was documentation from 05/01/21 through 05/24/21 Resident #1's catheter was cleaned with warm soapy water twice daily and the urine amount was recorded.
-There was documentation Resident #1 refused catheter care on 05/24/21 and 05/28/21.

Review of Resident #1's record revealed a hospitalization on 05/28/21 with a diagnosis of sepsis due to a urinary tract infection with sediment and pus in the Foley collection bag.

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D 269	Continued From page 10 Interview with a MA on 06/22/21 at 3:19pm revealed: -Resident #1's baseline was independent with activities of daily living, including his Foley catheter care, with assistance from staff as needed. -Resident #1 frequently reported to staff he had emptied his Foley catheter bag, documented his urine output and cleaned the tubing. -On the morning of 05/22/21, Resident #1 complained of stomach pains, and requested to be sent out to the ED. -Resident #1 reported he had not had a bowel movement recently. -He wanted to try some interventions before sending Resident #1 to the ED, so he administered a laxative and completed his shift before it was effective. -Resident #1 had not complained of stomach pain to him at any other time that week. Interview with a second MA on 06/23/21 at 1:35pm revealed: -She was the MA on 05/28/21. -She had worked at the facility earlier in the week and observed Resident #1 had a decreased appetite. -On 05/28/21 she observed Resident #1 was lethargic and complaining of stomach discomfort. -She contacted Resident #1's responsible family member and sent him to the ED to be assessed. -He had not returned to the facility and she did not know the hospital admitting diagnosis. Interview with a personal care aide (PCA) on 06/22/21 at 3:30pm revealed: -He emptied Resident #1's Foley bag and reported the urine amount to the MA. -The MAs cleaned the catheter tubing.	D 269		

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-He was trained on Foley care by the facility nurse shortly after he was hired.

Interview with a second PCA on 06/22/21 at 3:45pm revealed:
-She was not trained on Foley catheter care at this facility, but received training at her previous job.
-She did not clean Resident #1's Foley catheter tubing.
-She only emptied his Foley bag of urine and told the MA the amount she had emptied.
-Resident #1 sometimes emptied his own Foley bag and told us what the amount was.

Interview with the MA on 06/22/21 at 3:40pm revealed:
-The PCAs clean Resident #1's catheter tubing when he allowed them to provide care.
-When they cleaned the tubing and emptied the Foley bag she recorded it on the eMAR.
-She did not go behind the PCAs to ensure the care had been provided.

Interview with another PCA on 06/23/21 at 9:10am revealed:
-She had been a PCA for awhile and knew how to care for a Foley catheter.
-She emptied the urine bag on her shift and as needed, and reported the amount to the MA.
-She thought the MAs cleaned the catheter tubing or the HH nurse when she visited him.
-She did not clean Resident #1's catheter tubing.
-She did not remember receiving Foley care training when she was hired, but she had been trained in Foley care at a previous facility.

Interview with a second MA on 06/23/21 at 1:35pm revealed:
-The MA, PCA or resident would empty the urine

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from Resident #1's Foley bag.
-If the PCA emptied the urine, she would read the markings on the bag and report to the MA who would document it on the eMAR.
-If the resident emptied his own bag, he would report the amount to the PCA who would report the amount to the MA, and the MA would document on the eMAR.
-Resident #1 did most of his personal care including his catheter.
-He did not like staff to provide personal care to him most days, he was independent.
-She had not noticed any blood or pus in his Foley bag.
-She documented the care for the catheter tube as completed because the resident told her he had cleaned the tubing.

Interview with another MA on 06/23/21 at 2:15pm revealed:
-She usually worked second shift.
-She did not perform catheter care for Resident #1.
-She thought first shift cleaned the catheter tubing.
-When she documented catheter care and urine output on the eMAR, she was recording the urine output given to her by the PCA or Resident #1, not cleaning the tubing.
-She did not know the order was for cleaning the catheter tubing twice a day.

Interview with Regional Director of Resident Care on 06/23/21 at 10:45am revealed:
-She provided training for the Licensed Health Professional Support (LHPS) tasks the staff were required to be proficient with.
-She checked off the MAs for positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter.

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D 269	Continued From page 13 -She verbally reviewed the catheter care with the PCAs. -She also reminded them not to let the Foley catheter bag drag on the floor and keep the tubing from kinking. -She did not know the order to clean the tubing from the head of the penis to the end of the Foley tube twice a day was on the eMAR. -She did not instruct the staff to clean the catheter tubing twice a day. Interview with the MCM on 06/23/21 at 3:15pm revealed: -It was her expectation the MAs were to clean Resident #1's catheter tubing with warm soapy water from the head of the penis to the end of the Foley tube twice daily, on first shift and second shift, as ordered by the PCP. -The PCAs could empty the Foley bag of urine and report to the MA. -The MAs should document when they completed the care to Resident #1's catheter tubing and the report of the urine emptied each shift. -She did not know the MAs were not cleaning the entire catheter tubing with warm soapy water each shift. -A memory care resident should not be expected to reliably clean their catheter tubing twice a day. Interview with the Administrator on 06/23/21 at 1:55pm revealed: -Treatment orders and medication orders were entered on the eMAR by the pharmacy staff. -She and the MCM approved the orders before they were active orders on the eMAR. -Resident #1 was the first resident to have a Foley catheter in the building. -She conducted an in-service training with all the staff regarding the proper personal care of a resident with a Foley catheter.	D 269		

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-The MAs were trained to clean the tubing and observe the urine in the Foley bag for blood, pus and sediment, and to report to the MCM.
-The MAs were also to clean around the penis head and make sure there was no penal discharge.
-When the PCP wrote an order to clean the tubing twice a day with warm soapy water, she expected the MAs would perform the cleaning.
-She knew there were times the resident would refuse care, and the MAs were to report refusals to the MCM.
-She did not know the MAs were relying on the PCAs or the resident to clean the catheter tubing.
2. Review of Resident #3's current FL2 dated 04/14/21 revealed a diagnosis of dementia.

Review of Resident #3's care plan dated 11/20/20 revealed supervision level assistance was required for bathing, dressing, grooming and personal hygiene.

Review of the facility's "Who am I" document dated 04/26/21 revealed that Resident #3 required extensive staff assistance with bathing and dressing.

Review of shower schedule on 06/23/21 revealed that Resident #3 was scheduled for a shower on Monday, Wednesday and Friday on first shift.

Observation of Resident #3 on 06/21/21 (Monday) at 12:55pm revealed:
-The resident sat in a wheelchair and ate lunch.
-The resident wore a short sleeve t-shirt, brown shorts and non-slip socks.
-The resident was not wearing shoes.

Observation of Resident #3 on 06/22/21 (Tuesday) at 9:37am revealed:

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D 269	Continued From page 15 -The resident was sitting in a chair in the activity room sleeping. -The resident was wearing a brown striped short sleeved shirt, brown shorts and the same non-slip socks. Observation of Resident #3 on 06/23/21 (Wednesday) at 9:59am revealed: -The resident was asleep on the living room couch. -The resident wore a tan and black shirt, gray cartoon mouse lounge pants and black socks. -The resident had stubble on his chin and cheeks and dried mucus hanging out of the left nostril. -The resident had not been bathed. Observation of Resident #3 on 06/23/21 (Wednesday) from 10:20am- 2:30pm revealed: -The resident remained in the black and tan shirt, gray cartoon mouse lounge pants and black socks. -The resident had not been shaven or had the dried mucus removed from the left nostril. -The resident had not been bathed. Review of Resident #3's point of care history for 06/23/21 revealed: -Entries for personal care were listed on the left side of the page and included: tub bath or shower, upper body bathing, lower body bathing, bed bath and hair care once a day on Monday, Wednesday and Friday; skin care, put on clothing/socks/shoes and clothing and shoe fasteners every shift; shave once a day on Wednesday. -Entries with personal care provided down the right side of the page across from each of these tasks the personal care aide (PCA) had documented them "done" with her name following the comment at 1:27pm.	D 269		

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D 269	Continued From page 16 Interview with the same PCA on 06/23/21 at 10:50am revealed: -Resident #3 required assistance with dressing and bathing. -First shift showers were given sometimes before lunch was served since there were a lot of tasks to complete prior to lunch. -The residents stayed in their pajamas until they were given a shower. -Resident #3 was shaved on shower days. Interview with the medication aide (MA) on 06/23/21 at 10:20am revealed: -Resident #3 was typically dressed before she started her shift at 7:00am. -The resident liked to undress and required help to put clothes and shoes back on. -Resident #3 was given a shower on Monday, Wednesday and Friday and was washed with a wet washcloth on Tuesday, Thursday, Saturday and Sunday. -The resident was shaved on shower days. Interview with the Memory Care Manager (MCM) on 06/22/21 at 9:30am revealed: -The PCAs were responsible for reviewing the resident care plan located in the personal care notebook. -The PCAs were to document on the residents they provided personal care before their shift ended. -She had not printed the point of care history report and reviewed it. Interview with Administrator on 06/23/21 at 2:14pm revealed: -PCAs were expected to review a "Who am I" book that summarized the service plan for each resident.	D 269		

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-PCAs were expected to document in the point of care history log under their username after a task was completed. If a task was partially completed then the documentation should state that the task was incomplete.
-The MA audited the point of care history log at the end of the shift to check that all tasks were completed.
-The Administrator looked at the point of care history log to verify that it was complete, but she did not look closely at the information documented.
-The MCM was expected to audit the point of care log for accuracy.
-The Administrator expected residents to be out of their pajamas after breakfast. If she saw someone sitting in pajamas after breakfast then she would alert the MCM to have the resident changed.
-She was not aware Resident #3 remained in pajamas and had not been given a shower as was documented on the care log.
-She expected first shift showers to be completed by 2:00pm.

Based on observations, interviews and record review it was determined Resident #3 was not interviewable.

3. Review of Resident #5's current FL2 dated 02/08/21 revealed:
-Diagnoses that included Alzheimer's dementia, and gastroesophageal reflux disease.
-The resident was incontinent of bowel and bladder.

Review of Resident #5's Care Plan dated 05/04/21 revealed:
-Resident #5 required limited assistance with eating.

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D 269	Continued From page 18 -Resident #5 required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transfers to a wheelchair for mobility. Observation of Resident #5 on 06/21/21 (Monday) between 9:00am and 12:00pm revealed: -The resident was sitting in a wheelchair in the community room of the facility. -The resident was wearing gray pajamas and white house slippers. -The resident was unable to propel her wheelchair with her hands, so she used her feet to walk her wheelchair in the hallway requiring the personal care aide (PCA) to come and assist her to the dining room for lunch. Observation of Resident #5 on 06/21/21 between 1:30pm and 4:00pm revealed: -The resident was sitting in a wheelchair in the community room of the facility. -The resident was wearing gray pajamas and white house slippers. Observation of Resident #5 on 06/22/21 (Tuesday) between 8:00am and 9:30am revealed: -The resident was in her wheelchair in the hallway outside of the dining room. -The resident was wearing gray pajamas and white house slippers. -The resident had vomited phlegm and liquid stomach contents on her pajama top and pants. -The resident was attempting to maneuver her wheelchair using her feet when a PCA recognized the resident vomited on her clothes and smelled of urine. -At 8:15am the PCA pushed the resident in her wheelchair to the medication cart located outside in the hallway of the community room. -The PCA left the resident when the medication	D 269		

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aide (MA) returned to the medication cart.
-At 9:10am when the MA left another resident's room and returned to the medication cart she recognized the resident vomited on her clothes and smelled of urine.
-The MA proceeded to walk the hallways looking for the PCA and when she found her the PCA took the resident to the shower room to change her clothes and brief.

Review of Resident #5's point of care history for 06/21/21 revealed:
-Entries with personal care task list down the left side of the page included remove and fasten clothing, socks and shoes; tub bath or shower once a day on Monday, Wednesday, and Friday bathing upper body, lower body, shampooing hair, skin, nail and mouth care; provide hygiene after toileting and incontinence.
-Entries with personal care provided down the right side of the page across from each of these tasks the MA had documented them "done" with her name following the comment at 1:04pm.

Review of Resident #5's point of care history for 06/22/21 revealed:
-Entries with personal care task list down the left side of the page included fasten clothing, sock, and shoes; sponge bath once a day on Sunday, Tuesday, Thursday, and Saturday; skin care includes wash face/hands every shift, turn and reposition every shift; provide hygiene after toileting and incontinence.
-Entries with personal care provided down the right side of the page across from each of these tasks the MA had documented them "done" with her name following the comment at 11:06am.

Attempted telephone interview with Resident #5's responsible party on 06/22/21 at 1:30pm was

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unsuccessful.

Interview with the PCA on 06/22/21 at 2:15pm revealed:
-She provided all of Resident #5's personal care needs and checked on the resident every two hours.
-Resident #5 never refused a shower or personal care.
-Resident #5's shower day were Mondays, Wednesdays, and Fridays.
-She thought she gave Resident #5 a shower on 06/21/21 and changed her clothes.
-She did not believe Resident #5 wore the same clothes for the last two days.
-She did not have access on the computer under her own name to document Resident #5's personal care on the computer.
-She left Resident #5 in her wheelchair all the time when Resident #5 was out of her room.
-The MA never had to ask her if she provided personal care for Resident #5.

Interview another PCA on 06/22/21 at 2:28pm revealed:
-She made sure the residents were cleaned and changed after they soiled themselves.
-She did not document how many times she cleaned and changed any residents.
-She did not document the personal care on the computer because she did not have access on the computer under her own name to document it.

Interview with the MA on 06/22/21 at 9:00am revealed:
-The PCAs were responsible for completing all of Resident #5's personal care needs.
-There were some PCAs that did not have access on the computer under their own name to access

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the point of care program in the computer.
-The PCAs without access on the computer under their own name to access the point of care documentation used other PCAs or MAs log on when the computer was left logged on by the last user.
-She did not know why her name was documented as completing Resident #5's personal care in the computer.
-She did not know who was responsible for making sure the PCAs provided personal care and document it in the computer.

Interview with the Memory Care Manager (MCM) on 06/22/21 at 9:30am revealed:
-The PCAs were responsible for reviewing the resident care plan located in the personal care notebook.
-The PCAs were to document on the residents they provided personal care before their shift ended.
-She did not know PCAs were documenting under the MAs log in the computer because they did not have a log on to the computer.
-She had not printed the point of care history report and reviewed it.
-She did not intentionally monitor Resident #5's personal care daily.
-On the days, she had an opportunity to spend time with Resident #5 she did not notice her personal care was not completed.

Interview with the Administrator on 06/23/21 at 2:00pm revealed:
-PCAs were expected to review Resident #5's service plan in the "Who I am" notebook and provided Resident #5's required personal care needs.
-PCAs were expected to have their own log on to the computer to document the personal care they

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provided.
-The PCAs were provided a log on password during their orientation and were expected to use it.
-The MA assigned with a PCA was responsible for overseeing the PCAs to make sure they completed all Resident #5's personal care.
-The MCM was supposed to run the point of care report and discuss the findings during management stand up meetings that was held every morning.
-Yesterday (06/22/21) during the management stand up meeting she was informed by the MCM there were some PCAs signing into the computer under other staffs' passwords.
-She did not check behind the staff to make sure they completed the personal care.

Review of the facility's "Who I am" documents on 06/23/21 revealed there was no care plan for Resident #5 in the notebook.

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

_____

The facility failed to provide personal care for Resident #1 who had a Foley catheter and was not provided physician ordered catheter care which resulted in the resident being admitted to the hospital with a urinary tract infection and sepsis, Resident #3 who had dementia and required extensive staff assistance with bathing and dressing and Resident #5 who was wheelchair bound, required extensive staff assistance with toileting, bathing, dressing, grooming, and transfers resulting in the resident being left soiled and sitting for prolong periods in her wheelchair. This failure was detrimental to the residents' health and welfare and constitutes a

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D 269	Continued From page 23 Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 23, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED AUGUST 7, 2021.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews the facility failed to meet the health care needs for 2 of 5 sampled residents (#1 & #4) by failing to follow up with monthly visits to the urologist for Foley catheter exchanges, not following up with a procedure to replace the Foley catheter with a supra pubic catheter, and not sending the resident to the emergency department (ED) when he requested to be evaluated for abdominal pain (#1) and coordinating a urologist visit for a resident with an elevated prostate-specific antigen (PSA)(#4). The findings are: Review of Resident #1's current FL2 dated 04/09/21 revealed: -He was admitted to the facility on 04/01/19	D 273		

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-Diagnoses included seizure disorder, chronic obstructive pulmonary disease and urinary retention.
-He had an indwelling Foley catheter.

Review of Resident #1's hospital discharge summary dated 10/12/20 revealed:
-Resident #1 was admitted to the hospital for a grand mal seizure, urinary tract infection (UTI) and a bladder outlet obstruction (a blockage that stops the flow of urine).
-His creatinine level was 2.07 (a waste product filtered out of the blood by healthy kidneys, the normal reference range was 0.2-0.5 in males.)
-He had a large residual amount of urine after voiding, so a Foley catheter was inserted.
-Discharge instructions were for the Foley catheter to stay in place until a follow up appointment with the urologist to evaluate the bladder.
-A follow up appointment to a Nephrologist and orders for Home Health (HH) to evaluate and treat Resident #1 were included in the discharge instructions.

A request was made for documentation Resident #1 was seen by a Nephrologist and was not provided prior to survey exit.

Review of Resident #1's urologist's visit notes dated 10/22/20 revealed:
-Resident #1 was diagnosed with benign prostatic hyperplasia (BPH), which was an enlarged prostate gland that can cause urinary symptoms.
-The treatment plan was to continue the Foley catheter and return to the urology office monthly to change the catheter.

Review of Resident #1's Emergency Department (ED) discharge summary dated 10/25/21

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revealed:
-Resident #1 complained of abdominal pain he believed was related to constipation.
-CT Scan of the abdomen and pelvis showed bilateral hydronephrosis (the swelling of the kidneys due to the build up of urine since the urine was unable to drain properly.)
-There was evidence of a thickening of the lining of the bladder wall, which was the cause of the abdominal pain.
-The Foley catheter was changed and a follow up visit with the urologist within 4 weeks was included in the discharge instructions.

Review of Resident #1's urology visit notes on 11/17/20 revealed:
-The facility nurse removed Resident #1's catheter as directed prior to the visit to determine whether the resident could void on his own.
-He was unable to void and the Foley catheter was replaced in the office.
-The treatment plan was to return to the office in a month and assess whether the resident was able to void on his own.
-The urologist would do a catheter exchange at that time if Resident #1 was unable to void.

Review of Resident #1's urology visit notes dated 12/15/20 revealed:
-The facility nurse removed Resident #1's catheter as directed prior to the visit to determine whether the resident could void on his own.
-He was unable to void and the Foley catheter was replaced in the office.
-The treatment plan was to check the Basal Metabolic Panel (BMP) and Prostate Specific Antigen (PSA) in one week.
-Urodynamics (a group of tests to study the bladder and the flow of urine) was to be completed in 4 weeks.

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D 273	Continued From page 26 -Resident #1 was to return to the urology clinic in 4-6 weeks for a catheter exchange and a lab and diagnostic review. Review of Resident #1's record revealed there was no documentation a BMP or PSA had been checked. Review of the urology message center note dated 02/11/21, 02/15/21 and 02/22/21 revealed: -On 02/11/21, the Business Office Manager (BOM) left a message stating no one had contacted the facility regarding Resident #1's Urodynamic appointment (12/15/20) and she would like to schedule the appointment. -On 02/15/21 a message was left on the voicemail of the BOM regarding the Urodynamic appointment for Resident #1 and a fax number for orders. -On 02/22/21, the Home Health Nurse (HHN) left a message for Resident #1's urologist to determine when the Urodynamic testing was to be completed. -The catheter had been in place for over 2 months and the HHN was not comfortable changing it at the assisted living facility Review of the urology message center note dated 02/22/21, 02/23/21 and 03/04/21 revealed: -HHN requesting clarification if the catheter was to be changed before the Urodynamic appointment on 03/10/21. -The resident has had the same indwelling catheter since 12/15/20. -On 02/23/21, the urologist replied the catheter should be exchanged every month. The HHN should change the catheter now. -On 2/24/21, HHN requested an order from the urologist to change the catheter and the size of the catheter to be inserted.	D 273		

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-On 03/04/21, HHN reported she changed the catheter on 02/26/21 and met some resistance.
-The facility had contacted her on 03/04/21 to report the resident was experiencing a lot of pain and decreased urine output in the Foley catheter.
-On 03/05/21, the urologist requested Resident #1 should have regular follow up appointments.

Review of Urodynamic test results on 03/10/21 revealed:
-There was lower urinary tract symptoms due to benign prostatic hyperplasia (BPH).
-There was no bladder muscle activity.
-The Foley catheter bag was changed to a leg bag and attached to the resident's right thigh.

Review of the urologist office visit notes dated 04/13/21 revealed:
-Based on the results of the Urodynamic testing, Resident #1 will require catheterization for evacuation of the bladder.
-A suprapubic catheter was the best approach to relieving long term evacuation issues.
-The responsible family member would be contacted to provide consent, staff would coordinate with radiology and Resident #1's facility would be contacted to schedule the appointment.
-The resident should follow up with the urologist 6 weeks after the surgery for the initial catheter exchange.
-The follow up appointment was made for 05/24/21.

Telephone interview with the responsible family member on 06/21/21 at 11:50am revealed:
-Resident #1 had been at the facility for about 3 years.
-He had a Foley catheter put in last year at the hospital due to an inability to void.

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-The catheter was supposed to be changed every 30 days by HHN.
-The urologist was suggesting a suprapubic catheter would be a better option for him.
-She was not contacted by the facility or the urologist regarding a suprapubic catheter insertion date for her family member.
-She was contacted regarding the follow up appointment at the urologist office post surgical (05/24/21), and they canceled the appointment since he did not have the surgery.
-Resident #1 contacted her on 05/21/21 at 4:30am and stated he had severe abdominal pain and wanted to go out to the hospital.
-She contacted the facility immediately and requested Resident #1 be sent to the emergency department (ED).
-The medication aide (MA) reported he was possibly constipated and had given him a laxative.
-The MA wanted to wait and see if the laxative was effective.
-She did not hear back from Resident #1 or the facility staff until 05/28/21 when they reported he was being sent to the ED.

Review of the May 2021 electronic medication administration record (eMAR) revealed:
-There was no documentation Resident #1 received an as needed (prn) laxative on 05/21/21 between 11:00pm and 7:00am (third shift).
-There was documentation Resident #1 received a prn laxative on 05/21/21 at 4:49pm for constipation that was "somewhat effective".

Interview with the first shift MA on 05/21/21 at 3:10pm revealed:
-Resident #1 had not been eating and was refusing his medications a few days before he went to the hospital.

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-On 05/28/21, he did not look good and was complaining of stomach pains, so she contacted his responsible family member.
-She decided to send him to the hospital for further evaluation.
-She had not noticed any clouding or pus in his catheter bag and it was not reported to her by the PCA's.

Review of Resident #1's Emergency Medical Services (EMS) report on 05/28/21 at 9:42am revealed:
-The staff reported Resident #1 was complaining of abdominal pain but did not know how long he had been experiencing this pain.
-Resident #1 reported to EMS he had been having abdominal pain for weeks, and bouts of diarrhea.
-The pain was in all 4 quadrants of his abdomen, but the right lower quadrant was the most tender.

Review of Resident #1's hospital summary dated 05/28/21, 05/29/21 and 05/30/21 revealed:
-Resident #1 was "quite sick" with presumed urosepsis.
-Resident reports an episode of vomiting today and recent diarrhea with mild dyspnea.
-He had remained persistently hypotensive (low blood pressure) and tachycardic (elevated heart rate) with metabolic acidosis (a serious electrolyte disorder).
-His creatinine level was 13.70, up from 2.70 in December, and his BUN (blood urea nitrogen which indicates how well the kidneys were functioning) was elevated to 180, normal reference range was 2.8-8.9.
-The Intensive Care Unit (ICU) team agreed to admit Resident #1 to their services.
-A vascular catheter central line was attempted to be placed in the right jugular vein due to acute

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renal failure.
-Placement was unsuccessful due to resistance.
-On 05/29/21, Resident #1's Foley catheter had frank purulence (pus).
-On 05/30/21, Resident #1's urine and blood cultures came back positive for a bacterial infection.

Review of Resident #1's Infectious Disease physician's consultation notes dated 06/03/21 revealed:
-Diagnosis of urosepsis related to Foley catheter being retained too long and some thick purulent bladder debris obstructing Foley drainage.
-The resident needed a suprapubic catheter before discharge and this was discussed with the attending physician.

Review of the hospital urologist's progress notes dated 06/03/21 revealed:
-Per the Urology outpatient visit dated 04/13/21, Resident #1 was to be scheduled for a suprapubic placement and to return in 6 weeks to perform the first exchange.
-It was unclear as to why he did not follow up as planned.
-He has been diagnosed with urinary sepsis due to urinary retention and grossly purulent urine.
-He suspected after initial placement, the catheter became clogged with grossly purulent debris and was not draining effectively.
-There was no evidence at this time of purulent urine, and the catheter was draining effectively.
-Suprapubic tubing placement was scheduled for 06/04/21.

Telephone interview with the third shift MA on 06/23/21 at 3:40pm revealed:
-On 05/21/21, Resident #1 complained of abdominal pain he thought was due to

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constipation.
-He administered Resident #1 a laxative at approximately 4:15am.
-The responsible family member called the facility shortly after that and he forgot to document the administration.
-Resident #1 had called her requesting the resident be sent to the ED due to abdominal pain.
-He reported to the family member that he had just administered a laxative to the resident and was waiting to see if it was effective.
-He did not want to send a resident out to the ED until he had implemented some interventions to rule out other causes.
-When he left his shift at 7:00am, the laxative had not been effective.
-He had not been told of any other time during the week Resident #1 had abdominal pains.

Telephone interview with the second shift MA on 06/23/21 at 4:10pm revealed:
-On 05/21/21, Resident #1 had complained of constipation on her shift.
-She administered a prn laxative to him.
-The laxative was "somewhat effective" on her shift.
-She did not remember Resident #1 asking to go out to the hospital.
-He had not complained to her of constipation or abdominal pains the rest of that week when she worked.
-She would send a resident out to the hospital if they requested to go.

Review of the May 2020 eMAR from 05/21/21 through 05/28/21 revealed:
-There was an entry to empty the Foley catheter bag of urine twice a day, on first shift (7:00-3:00pm) and second shift (3:00pm-11:00pm)

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and record the amount of urine.
-There was documentation on 05/21/21 the amount of urine emptied from the catheter bag was 400ml on first shift and 200ml on second shift.
-There was documentation on 05/22/21 the amount of urine emptied from the catheter bag was 200ml on first shift and 400ml on second shift.
-There was documentation on 05/23/21 the amount of urine emptied from the catheter bag was 300ml on first shift and 200ml on second shift.
-There was no documentation, from 05/21/21 through first shift on 05/26/21, of urine emptied from Resident#1's catheter bag.
-There was documentation on 05/26/21, second shift, the amount of urine emptied from the catheter bag was 200ml.
-There was documentation on 05/27/21 the amount of urine emptied from the catheter bag was 300ml on first shift.
-There was no documentation of urine output on 05/27/21 second shift or 05/28/21.

Telephone interview with the primary care provider (PCP) on 06/22/21 at 9:50am revealed:
-Resident #1 returned from a hospital visit last October 2020 with a Foley catheter due to an inability to void.
-He was seeing a urologist who exchanged the catheter monthly in November and December 2020.
-The facility staff was managing the Foley catheter between December 2020 and February 2021.
-The staff were cleaning the site and looking for intactness of catheter.
-Resident #1 was non compliant with his care and was refusing to allow the staff to manage his

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Foley, so he wrote an order for Home Health to manage the catheter.
-According to the urologist's visit notes, Resident #1 should have had an appointment to place a suprapubic catheter instead of a Foley catheter.
-He did not know why that procedure was not done.
-If a resident requested to be sent out to the hospital with abdominal pain, the staff should send them out.

Interview with HHN Office Coordinator on 06/22/21 at 12:53pm revealed:
-HHN received an order from Resident #1's PCP on 02/16/21 to provide monthly visits for the care of Resident #1's indwelling Foley catheter.
-There was no documentation of an order received for HH to follow Resident #1 after his hospitalization on 10/12/20.
-HHN start of care was from 02/18/21 through 06/16/21.
-The HHN protocol for any resident who had a Foley catheter was to change the catheter every 4-6 weeks, as needed or per physician's orders.

Interview with the Memory Care Manager (MCM) on 06/22/21 at 1:45pm and 06/23/21 at 1:35pm revealed:
-She knew the Regional Registered nurse (RN) had removed Resident #1's catheter before his urology appointment on 12/15/21.
-She was not aware the catheter had been reinserted at the appointment.
-The transportation driver did not return with physician visit notes.
-She attempted to contact the urologist's office twice to get a copy of the visit notes and was unsuccessful.
-She was not aware Resident #1 had a Foley catheter until February 2021, and then proceeded

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to request an order for HH to manage.
-Resident #1 complained of his catheter bothering him, so she made an appointment for him to be seen at the urologist's office on 04/13/21.

Interview with the Regional Director of Resident Care on 06/23/21 at 10:45am revealed:
-She completed the LHPS tasks for the residents in the facility.
-The MCM or Administrator informed her of residents who needed tasks to be checked off.
-She completed an LHPS for Resident #1 on 01/07/21.
-The only task she had been informed of was a B12 injection administered by the HHN.
-She did not know Resident #1 had a Foley catheter at that time.
-She relied on the staff to inform her of LHPS tasks for each resident.

Interview with the Administrator on 06/22/21 at 2:30pm and 06/23/21 at 3:30pm revealed:
-The transportation staff kept an appointment book with the resident's appointments and the appointments were also uploaded into the software program.
-The process for sending residents to their physician appointments was for the staff to print the physician referral form and the resident's physician orders from the computer and take them to the visit.
-Staff transporting residents to their appointments were instructed to return with physician office visit notes.
-When office visits notes were not returned the MCM should call the physician's office to request them.
-After 2 calls to the office, the Administrator or the MCM should go to the office and request the notes.

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D 273	Continued From page 35 -She did not know Resident #1 had missed 2 appointments to the urologist to obtain blood work, a urodynamic test and 2 catheter exchanges for his Foley catheter. -She thought the urologist's office was waiting for the responsible family member to consent to Resident 1's suprapubic procedure. -She thought the appointment in May 2021 with the responsible family member and Resident #1 was to discuss the procedure, not a follow up after the procedure. -She thought the family member had canceled the procedure because she did not want him to go to a rehabilitation facility to heal. -She did not know Resident #1 had abdominal pain and requested to go to the ED on 05/21/21. -A MA should always send a resident to the ED if they are in pain-it is their right to be seen. A request was made for documentation Resident #1 was seen by a Nephrologist from 12/01/21 through 05/25/21 and was not provided prior to survey exit. A request was made for documentation Resident #1 had his BMP and PSA checked one week from 12/15/21 and was not provided prior to survey exit. 2. Review of Resident #4's current FL2 dated 01/12/21 revealed diagnoses included diabetes, vascular dementia and bipolar disorder. Review of a face-to-face primary care provider (PCP) encounter for Resident #4 dated 04/24/21 revealed the resident's clinical note directive instructions addressing follow up visit related to an elevated prostate-specific antigen (PSA) of 4.7 (normal range 0.6-0.7) required a urologist consult appointment.	D 273		

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D 273	Continued From page 36 Review of Resident #4's record on 06/22/21 revealed: -There was no documentation for a face-to-face encounter note with Resident #4's urologist. -There was no documentation of a scheduled urologist appointment. Attempted telephone interview with Resident #4's responsible party (RP) on 06/22/21 at 1:30pm was unsuccessful. Interview with the Memory Care Manager (MCM) on 06/23/21 at 9:30am revealed: -She was responsible for ensuring directives given on the PCP face-to-face encounter notes had been addressed. -She did not know Resident #4 needed a referral for a urologist for his elevated PSA. -Resident #4 had not seen a urologist since the PCP face-to-face encounter on 04/27/21. -She received a stack of PCP face-to-face encounter notes on all the residents seen on 04/27/21 sometime during the following week after the PCP visited the facility. -She did not read all the PCP face-to-face encounter notes but filed them in each residents' record because she did not have enough time to do so with all her other job responsibilities. -She depended on Resident #4's PCP's office to contact the facility when Resident #4 had an appointment with a urologist. Interview with Resident #4's PCP on 06/23/21 at 10:20am revealed: -He saw Resident #4 on 04/27/21 for a follow up visit after a lab was drawn indicating the resident's PSA level was 4.7. -He informed the MCM Resident #4 required a referral to see a urologist during his visit on	D 273		

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D 273	Continued From page 37 04/27/21. -He was informed today (06/23/21) that the MCM had not been made aware of the referral for a urologist. -He had his medical assistant contact the scheduler in his office to set up an appointment with a urologist today (06/23/21) -The MCM did not reach out to his office to follow up on Resident #4's urologist referral. Interview with the Administrator on 06/23/21 at 2:00pm revealed: -The MCM was responsible for ensuring residents are scheduled for appointments with their medical specialist. -She depended on the MCM to review all the PCP's visit notes and arrange for referrals to be set up with their medical specialist. -The MCM was expected to keep track of all referrals and follow through with their PCP to make sure the residents' referrals were made. -She did not have a system in place to make sure the residents' medical specialist referrals were completed. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable. _____ The facility failed to provide physician referral and follow up for Resident #1 with monthly visits to the urologist for Foley catheter exchanges, not following up with a procedure to replace the Foley catheter with a supra pubic catheter, not referring the resident to the nephrologist and not sending the resident to the emergency department (ED) when he requested to be evaluated for abdominal pain which resulted in the resident being sent to the ED, admitted to the ICU for 6 days with a urinary tract infection, a blood infection and	D 273		

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D 273	Continued From page 38 kidney dysfunction; and Resident #4 who had a PSA of 4.7 and was not seen by a urologist. The facility's failure resulted in physical harm and risk for serious neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on June 22, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 23, 2021.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all food items stored by the facility were protected from contamination related to undated food, expired food and food not properly stored in the refrigerator. The findings are: Review of the sanitation rating score for the kitchen revealed a score of 97.5 on 05/21/21.	D 283		

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WILLOW RIDGE ASSISTED LIVING	2140 MILTON ROAD CHARLOTTE, NC 28205

(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 283	Continued From page 39 Observation of the refrigerator and freezer in the kitchen on 06/21/21 at 10:54am to 11:05am revealed: -A four-quart tub of vanilla pudding that was covered with clear plastic wrap which had a hole in the left corner approximately 1.5 inches in diameter and was stored under a dirty shelf. -A sign on the door that instructed food to be labeled, dated and then thrown away after five days. -A container of sour cream with an open date of 04/09/21 and a manufacturer best by date of 05/17/21. The container had a sour smell and small white spots of mold. -A container of unopened cottage cheese with a manufacturer best by date of 11/27/20. -A printed refrigerator storage chart that recommended to always store ready to eat foods on the top shelf and arrange the other shelves by cooking temperature with the highest cooking temperature on the bottom. -A cardboard box of 12 shelled eggs and 13 cartons of liquid eggs were stored next to ready to eat food. -A spill of partially frozen brown liquid on the freezer floor. -Black spots, that were easily chipped off with a fingernail, on both shelves of the refrigerator. Interview with the Dietary Manager (DM) on 06/21/21 at 11:05am and 2:37pm revealed: -She was hired on 06/08/21. -She was responsible for properly storing the food after food was delivered. -She and the cook were responsible for the daily disposal of expired foods. -She did not know there were containers of expired sour cream and cottage cheese in the refrigerator. She knew that dairy products should be disposed of after their best by date from the	D 283		

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manufacturer.
-She covered all prepared foods and did not know why the plastic wrap on the four-quart tub of vanilla pudding had a hole in it.
-She, the cooks and dietary aides were responsible for cleaning up spills or other messes.
-She was aware of the partially frozen brown liquid spill in the reach in freezer and thought that it had been there for over two weeks. She had not had time to clean the reach in freezer.
-She was not aware of the black spots on the shelves of the cooler but knew it was her responsibility to keep the refrigerator clean.
-She had not received a cleaning schedule from the Administrator.

Telephone interview with the Local Environmental Health Inspector on 06/23/21 at 9:03am revealed:
-Food should be used or discarded within seven days of being opened.
-Food that was kept after seven days could be at risk for spoilage. An older person that has consumed spoiled food would be at risk for a food borne illness due to a decreased immune system.
-An open container of food was at risk for contamination by whatever might fall into the container. The partially exposed container of pudding was at risk of contamination by the black particles that were on the shelf above it.
-Raw eggs should not be stored next to ready to eat food because if raw egg contents leaked onto foods that did not require cooking the food could become contaminated and could cause salmonella.
-Unclean kitchen equipment and storage could lead to contamination of foods and pose a food safety risk.
-He did not observe the spill in the reach-in freezer or the black spots on the shelves of the

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refrigerator in the kitchen on his inspection on 05/14/21.
-Unclean kitchen equipment would result in a demerit on the environmental and sanitation report.

Interview with the Administrator on 06/23/21 at 1:40pm revealed:
-The DM was responsible for making sure that food was fully covered and stored properly to prevent contamination.
-She expected the DM would ensure that food was discarded within five days of being prepared.
-She expected the dietary staff to keep the kitchen clean.
-Anything that was spilled in the kitchen should be addressed immediately.
-She expected that the kitchen equipment would be cleaned daily.
-The DM was responsible for making the cleaning schedule.

Observation of the refrigerator in the medication room on 06/22/21 and 06/23/21 revealed:
-A sign on the refrigerator door that read "Resident Food Only Anything else will be thrown away".
-The temperature of the refrigerator was 10 degrees Fahrenheit (F) based on a portable thermometer in the back of the refrigerator.
-There was not a temperature log on or next to the refrigerator.
-Some of the foods and beverages were not in their original packaging and did not have manufacturer expiration dates.
-Some foods were not labeled with the resident's name.
-None of the foods or beverages were dated when they were brought into the facility.
-There was a block of yellow cheese in a plastic

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storage bag that was not dated.
-There were chicken tenders in a takeout box that was not dated.
-There was a 4 oz container of yogurt with the foil cover partially opened and a best buy date of 05/23/21.
-There was a 1-liter container of honey thick juice that was opened on 02/02/21 and had a use by date of 03/30/21.

Interview with a medication aide (MA) on 06/22/21 at 2:52pm revealed:
-The refrigerator was used to store foods and beverages that the resident's families provided.
-The food was supposed to be dated.
-She was not sure who was responsible for keeping the refrigerator clean or throwing away expired food.

Telephone interview with the Health Inspector on 06/23/21 at 9:03am revealed:
-He did not inspect the refrigerator in the medication room and only looked at the refrigerator in the kitchen.
-He would expect food to be disposed of after it was opened for seven days.

Interview with the Memory Care Manager (MCM) on 06/23/21 at 2:30pm revealed:
-The refrigerator in the medication room was for residents' food that was provided by family members.
-The Administrator was responsible for cleaning out the refrigerator.

Interview with the Administrator on 06/23/21 at 1:40pm revealed:
-The refrigerator in the medication room was to store extra food that the residents' family provided.

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D 283	Continued From page 43 -She, the Business Office Manager or the MCM were responsible for labeling and dating the food. -The three of them were responsible for discarding expired food every 1-1 1/2 weeks.	D 283		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews and record review the facility failed to document foods that were actually served to the residents when substitutions to the menu were made. The findings are: Review of the lunch menu on 06/21/21 revealed that a chocolate cream pie was to be served for dessert for all diet orders. Observation of the dessert served during the lunch meal service on 06/21/21 at 12:30pm revealed that all diets received chocolate cream pie except for residents on pureed diets who received vanilla pudding. Interview with the Dietary Manager (DM) on 06/21/21 at 8:25am and 06/22/21 at 2:37pm revealed:	D 292		

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D 292	Continued From page 44 -She was hired 06/08/21 and had not received any formal training for the kitchen since being hired. -The second shift cook gave her advice on how to puree food since the she did not have experience with therapeutic diets at her previous job. -There were diagrams posted on the kitchen wall that explained what the consistency of pureed food should look like. -She would also search the internet to find out how to puree some items. -She made the decision to serve vanilla pudding for dessert to residents on a pureed diet because the pudding would be better for them than the chocolate cream pie. -She did not document the menu substitution because the kitchen was out of substitution sheets for the substitution log. -She had not documented any menu substitutions since she was hired on 06/08/21. Telephone interview with the contracted Registered Dietitian on 06/23/21 at 9:22am revealed the recipes provided with the planned menu items had instructions that explained how to modify the food texture to a pureed consistency and the recipe should be followed. Review of the dinner menu for 06/22/21 revealed fish sticks with tarter sauce, dill new potatoes, green salad, milk sherbet was planned. Observation of the dinner meal service prepared on 06/22/21 at 4:45pm revealed pot roast, green beans and dinner rolls. Interview with the cook on 06/22/21 at 4:45pm revealed: -The facility did not have the ingredients on hand to make the planned meal so she chose a	D 292		

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D 292	Continued From page 45 different dinner that was on the menu several weeks ago. -Instead of documenting the menu substitution she planned to verbally tell the Administrator what she had substituted. Interview with the Administrator on 06/23/21 at 1:40pm revealed: -She knew that menu substitutions should be documented. -She knew that the substitution log had been difficult to find since the last DM left approximately 3 weeks ago and forgot to ask the DM or cook if the log had been located. -She did not give dietary staff instructions to document substitutions in an alternate place until the substitution log was found. -She expected the chocolate cream pie to be pureed so the residents required pureed foods could have the same dessert as the other residents.	D 292		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure therapeutic	D 310		

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diets were served as ordered for 1 of 3 sampled residents with an order for a pureed diet with nectar thickened liquids.

The findings are:

Review of Resident #3's current FL2 dated 04/14/21 revealed diagnosis included dementia.

Review of diet order sheet for Resident #3 dated 04/07/21 revealed the Primary Care Provider (PCP) ordered a pureed diet with nectar thickened liquids.

Review of the week at a glance menu for 06/21/21-06/27/21 revealed milk was to be served for breakfast and dinner each day.

Review of the therapeutic diet list posted in the kitchen revealed Resident #3 was to be served a pureed diet with nectar thick liquids.

Observation of the pre-thickened beverages on hand on 06/21/21 at 8:24am revealed:
-Multiple 46 oz cartons of nectar thick orange juice, nectar thick sweetened tea with lemon and nectar thick lemon flavored water located in dry storage.
-Two 46 oz cartons of nectar thick lemon flavored water, 1 carton of nectar thick sweetened tea with lemon and 1 carton of nectar thick orange juice in the refrigerator in the kitchen.
-There was not any nectar thick milk on hand.

Interview with personal care aide (PCA) on 06/22/21 at 8:50am revealed that Resident #3 drank nectar thick orange juice and nectar thick water with breakfast that morning.

Interview with the Dietary Manager (DM) on

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06/21/21 at 11:05am and 06/22/21 at 2:37pm revealed:
-She knew that one resident required nectar thickened beverages.
-The Administrator ordered the food and beverages for the kitchen since the DM had not been trained to order at that time.
-She remembered seeing nectar thick water, nectar thick lemonade, nectar thick iced tea and nectar thick orange juice in the refrigerator. She did not remember having any nectar thick milk in the refrigerator for the last two weeks.
-The dietary aides or PCAs poured the beverages for meals and she had not been asked to thicken milk for a resident.

Observation of the DM prepare a pureed lunch meal on 06/21/21 at 12:10pm revealed the facility had single serving packets of nectar thick thickening powder.

Observation of the Administrator in the dining room during the lunch meal service on 06/21/21 at 12:15pm revealed:
-She had a gallon of milk in her hand and offered milk to every resident seated in the dining room.
-Resident #3 was not seated in the dining room.

Observation of the dining room on 06/21/21 at 12:55pm revealed Resident #3 was the only resident in the dining room and none of the staff offered him milk.

Interview with the cook that prepared the dinner meal service on 06/22/21 at 4:45pm revealed:
-She did not remember the last time there was pre-thickened milk on hand.
-She was not responsible for pouring beverages at dinner and had not been asked to thicken milk by a PCA or dietary aide.

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D 310	Continued From page 48 Interview with the contracted Registered Dietitian on 06/23/21 at 9:22am revealed: -Milk should be served at the appropriate consistency for all residents. -If milk was excluded from a resident's diet than it could be difficult to meet the resident's daily recommended intakes for protein, vitamin D, phosphorus and calcium. Interview with the Primary Care Provider (PCP) on 06/23/21 at 11:30am revealed: -The facility reported Resident #3 was having difficulty chewing and swallowing so he ordered a pureed diet with nectar thick liquids. -He expected the facility to serve a balanced diet for all diet orders and was not informed that Resident #3 was not offered milk. -Resident #3 was prescribed vitamin D supplements on 04/14/21 due to a deficiency found on a routine laboratory assessment. Interview with the Administrator on 06/23/21 at 1:40pm revealed: -She ordered food and beverages for the kitchen and was not aware that the kitchen was out of nectar thickened milk. -She did not order nectar thick milk every week and could not provide a date that it was ordered prior to the survey. -She expected the kitchen to thicken milk with nectar thick powder packets for Resident #3 until the pre-thickened milk arrived on the food delivery truck. -She was not aware Resident #3 was not offered milk for the last three days.	D 310		
D 316	10A NCAC 13F .0905 (c) Activities Program	D 316		

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D 316	Continued From page 49 10A NCAC 13F .0905 Activities Program (c) The activity director, as required in Rule .0404 of this Subchapter, shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents	D 316		

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were offered activities designed to promote the residents' active involvement.

The findings are:

Review of the facility's June 2021 activity calendar on 06/21/21 at 9:55am revealed:
-The activity calendar was posted on the wall in the main hallway.
-There were 4 activities scheduled daily Monday through Friday, 2 activities scheduled on Saturdays, and 2 activities scheduled on Sundays in the month.
-On 06/21/21 from 9:30am to 10:00am, "senior scoop" was scheduled.
-On 06/21/21 from 11:00am to 11:30am, "chair exercises" were scheduled.
-On 06/22/21 from 9:30am to 10:00am, "devotion" was scheduled.
-On 06/22/21 from 11:00am to 11:30am, "walking club" was scheduled.
-On 06/22/21 from 1:00pm to 2:00pm, "birthday party" was scheduled.

Observations on 06/21/21 between 8:15am and 12:15am revealed:
-There were 12 to 18 residents sitting in the television room with the television playing the local news and morning show.
-There were no staff observed interacting with the residents or asking the residents to participate in "senior scoop" the scheduled activity from 9:30am to 10:00am.
-There were no staff observed interacting with the residents or asking the residents to participate in "chair exercises" the scheduled activity from 11:00am to 11:30am.
-There were 3 to 6 residents and 1 to 2 staff in the outside enclosed courtyard smoking cigarettes.

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D 316	Continued From page 51 -There were no staff or residents in the activities room. Observations on 06/22/21 between 8:15am and 2:00pm revealed: -There were 8 to 14 residents who sat in the television room with the television playing the local news, morning show and sitcoms. -There were no staff observed interacting with the residents or asking the residents to participate in "devotions" the scheduled activity from 9:30am to 10:00am. -There were no staff observed interacting with the residents or asking the residents to participate in "walking club" the scheduled activity from 11:00am to 11:30am. -There were no staff observed interacting with the residents or asking the residents to participate in "birthday party" the scheduled activity from 1:00pm to 2:00pm. -There were 3 to 6 residents and 1 to 2 staff in the outside enclosed courtyard smoking cigarettes. -There were no staff or residents in the activity room. Interview with a personal care aide (PCA) on 06/22/21 at 2:00pm revealed: -She took the residents to the dayroom to watch television and she started movies for them to watch. -She put music on in their rooms. -Since the Activity Director left approximately 3 weeks ago she did not gather the residents for the scheduled activities on the calendar. -No one told her to get the residents together to do activities on the calendar. Interview with another PCA on 06/22/21 at 2:15pm revealed she was never told to involve	D 316		

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the residents in activities so she did not do activities with them.

Interview with a medication aide (MA) on 06/21/21 at 9:50am revealed:
-There was an Activity Director hired to do activities, but she quit approximately three weeks ago.
-Staff were not given any guidance on promoting the activities on the activity calendar.
-She had not seen the residents gathered to do group activities since the Activity Director quit.

Interview with another MA on 06/22/21 at 10:45am revealed:
-She did not have time to lead the residents' scheduled activities.
-She did not know how to carry out some of the scheduled activities like "chair exercises".
-She was never told to get the PCAs involved in activities with the residents.

Interview with the Business Office Manager (BOM) on 06/22/21 at 1:00pm revealed she did activities with the residents when she worked on the weekends.

Interview with the Memory Care Manager (MCM) on 06/22/21 at 1:35pm revealed she was not able to find time to get the residents involved with the scheduled activities, and the residents had no group activities since the Activity Director quit 3 weeks ago.

Interview with the Administrator on 06/22/21 at 2:45pm revealed:
-Since the Activity Director quit 3 weeks ago, she intended to get together with the BOM and MCM to set up an alternative activities schedule until a new Activity Director was hired.

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D 316	Continued From page 53 -She had not found the time and failed to follow through with her plan.	D 316		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable records of the administration of controlled substances were maintained, accurate and reconciled for 1 of 3 sampled residents (Resident #6) who was prescribed a pain medication which was a controlled substance. Review of Resident #6's FL2 dated 05/21/21 revealed: -Diagnoses included alzheimer's dementia, and arthritis. -There was an order for Percocet 5/325mg(a schedule II narcotic opioid medication used to treat severe pain) every 8 hours. Observation of Resident #1's medications on hand on 06/23/21 at 12:45pm revealed: -There was one 30 count bubble pack with 26 tablets of Percocet 5/325mg available to administer. -There were three 30 count bubble pack with 30	D 392		

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tablets of Percocet 5/325mg available to administer in each bubble pack.
-Resident #6 had a total of 116 tablets of Percocet 5/325mg available for administration.

Review of the facility's Control Substance Count Sheet (CSCS) revealed Resident #6 had 116 tablets of Percocet 5/325mg left for administration.

Telephone interview with a pharmacy representative on 06/23/21 at 1:45pm revealed:
-The pharmacy had a record of Resident #6's FL2 dated 05/20/21 with an order for Percocet 5/325mg every 8 hours.
-On 05/20/21, the pharmacy dispensed 90 tablets of Percocet 5/325mg to the facility for Resident #6 and delivered them the next day.
-On 06/15/21, the pharmacy dispensed 90 tablets of Percocet 5/325mg to the facility for Resident #6 and delivered them the next day.
-On 06/22/21, the pharmacy received a new electronic physician's order for Percocet 5/325mg twice daily and delivered 60 tablets on 06/22/21 for Resident #6.
-The pharmacy sent a CSCS to the facility with each dispensed date for the Percocet 5/325mg.
-The pharmacy dispensed 240 tablets of Percocet 5/325mg for Resident #6 from 05/21/21 to 06/22/21.
-None of Resident #6's Percocet 5/325mg dispensed were returned to the pharmacy.

Review of Resident #6's May 2021 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Percocet 5/325mg every 8 hours at 6:00am, 2:00pm and 10:00pm.
-The Percocet 5/325mg was documented as

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administered from 05/21/21 to 05/30/21 at 6:00am, 2:00pm and 10:00pm.
-The Percocet 5/325mg was administered 33 times in May 2021.

Review of the facility's Control Substance Count Sheet (CSCS) that corresponded to the May 2021 eMAR revealed Resident #6 was administered 33 tablets of Percocet 5/325mg with 57 tablets remaining.

Review of Resident #6's June 2021 eMAR revealed:
-There was a computer-generated entry for Percocet 5/325mg every 8 hours at 6:00am, 2:00pm and 10:00pm.
-The Percocet 5/325mg was documented as administered from 06/01/21 to 06/18/21 at 2:00pm.
-On 06/18/21 at 10:00pm to 06/21/21 at 2:00pm the Percocet 5/325mg was documented with a "T" indicating Resident #6 was out of the facility on therapeutic leave missing 9 doses that were not administered at the facility.
-The Percocet 5/325mg was documented as administered from on 06/21/21 at 10:00pm and on 06/22/21 at 6:00am.
-On 06/22/21 there was a computer-generated entry for Percocet 5/325mg every 8 hours at 6:00pm, 2:00pm and 10:00pm to be discontinued.
-On 06/22/2, there was a computer-generated entry to start Percocet 5/325mg twice daily at 8:00am and 4:00pm.
-The Percocet 5/325mg was documented as administered on 06/22/21 at 4:00pm and on 06/23/21 at 8:00am.
-The facility administered 57 doses of Percocet 5/325mg from 06/01/21 to 06/23/21 at 8:00am.

There was no facility Control Substance Count

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D 392	Continued From page 56 Sheet (CSCS) available that corresponded to Resident #6's June 2021 eMAR. Review of Resident #6's documented and dispensed record of Percocet 5/325g record revealed: -The pharmacy dispensed 240 tablets of Percocet 5/325mg from 05/01/21 to 06/23/21. -Resident #6's May 2021 and June 2021 eMARs revealed Resident #6 was administered 86 tablets from 05/21/21 to 06/18/21 at 2:00pm. -Resident #6's June 2021 revealed Resident #6 was out of the facility from 06/18/21 to 06/21/21 at 2:00pm and was not administered 9 tablets at the facility of Percocet 5/325mg. -Resident #6 was administered 4 tablets of Percocet 5/325mg from 06/21/21 at 10:00pm to 06/23/21 at 8:00am. -Resident #6 was administered a total of 99 tablets Percocet 5/325mg at the facility. -Resident #6's CSCS revealed Resident #6 had 116 tablets remaining. -There were 34 tablets of Percocet 5/325mg not accounted for. Review of Resident #6's medication release form dated 06/18/21 to 06/21/21 revealed: -Resident #6 departed from the facility on 06/18/21 and returned on 06/21/21. -A handwritten entry for "oxycodone every eight hours at 10:00pm and 6:00am", (Percocet was not the medication, and the 2:00pm administration time was not included) 34 was documented in the quantity leaving column and 0 was documented in quantity returned column. -A medication aide(MA) signed the document on 06/18/21. -The Memory Care Manager(MCM) signed the document on 06/21/21. -Resident #6's responsible party(RP) signed the	D 392		

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document on 06/18/21 acknowledged she was instructed on the use, dosage, frequency and use of the "oxycodone" along with assuming the responsibility that the Percocet was properly stored and administered.

Telephone interview with Resident #6's responsible party (RP) on 06/23/21 at 1:15pm revealed:
-She arrived at the facility around 7:00pm on 06/18/21 to pick up Resident #6.
-The second shift MA gave her a plastic bag with all of Resident #6's medications inside it.
-She signed a form releasing the medications in the plastic bag.
-The second shift MA did not take the medications out of the plastic bag and count them with her.
-The second shift MA did not sign her name on the release form, and it was signed by another MA and the MCM.
-She administered 10 tablets of Percocet to Resident #6 from 06/18/21 to 06/21/21.
-She did not write down the times she administered Resident #6's Percocet.
-She hid Resident #6's medications in the oven to keep them out of reach and secure.
-She brought Resident #6 back to the facility on 06/21/21 around 4:00pm.
-The MCM took the remaining medications she was returning to the facility for Resident #6.
-She watched the MCM take the plastic bag of medications and lock them in the medication cart.

Interview with the MA on 06/23/21 at 8:15am revealed:
-Resident #6 was out of the facility from 06/18/21 to 06/21/21 on therapeutic leave.
-When she began her shift at 7:00am on 06/22/21 she counted Resident #6's Percocet with the third

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shift MA and discovered there were approximately 25 tablets missing from the medication cart.
-When the MCM arrived to work on 06/22/21 she reported her finding to the MCM.
-Since started working at the facility, she did not receive any training on the proper management of releasing medications to be administered outside the facility when a resident was on leave or an appointment.

Telephone interview with the first shift MA on 06/23/21 at 10:48am revealed:
-The MCM told her to complete a medication form for Resident #6 because he was going out on leave with his family for the weekend.
-She completed the medication release form for Resident #6, counted Resident #6's medications with the MCM and the MCM signed the medication release form.
-When the second shift MA arrived at shift change on 06/18/21 she informed her Resident #6 was going home for leave with his family for the weekend.
-She showed the medication release form to the second shift MA and left to go home.

Telephone interview with the second shift MA on 06/23/21 at 10:55am revealed:
-When she arrived to work on 06/18/21 the first shift MA informed her Resident #6 was going home for the weekend.
-During shift change she counted the controlled substances on the medication cart including Resident #6's controlled medications that were placed in a plastic bag for Resident #6's family with the first shift MA.
-When Resident #6 left she took the plastic bag with his medications out of the medication cart and gave them to Resident #6's RP.

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D 392	Continued From page 59 -She had Resident #6's RP sign the medication release form and kept the medication release form in the medication cart. -She was not instructed to count the medications with Resident #6's RP when Resident #6's RP took them from the facility. -She was not instructed by the MCM or the first shift MA to review the medications release form for accuracy and sign with another witness that Resident #6's RP understood how to administer the medications, keep them safe, secure with an accurate count of the medications leaving the building. Interview with the MCM on 06/23/21 at 9:00am revealed: -On 06/21/21 between 3:00pm and 4:00pm Resident #6's RP brought Resident #6 back to the facility. -She took Resident #6's plastic bag of medications to the second shift MA and the plastic bag of medications were returned to the medication cart. -She did not count and reconcile the medications when they were returned to the medication cart because she expected the MA on duty would count them before the MA administered any of the medications in the plastic bag. -On 06/22/2, the first shift MA informed her the count of Resident #6's Percocet was not accurate, and there were 24 tablets of Percocet missing from the medication cart. -When she recognized the Percocet might not have been returned to the facility, she contacted Resident #6's RP who reported she returned all of them to the facility on 06/21/21 that were left in the plastic bag. -On 06/18/21, during the management meetings held by the Administrator she was told Resident #6 was going to go out on leave for the weekend.	D 392		

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D 392	Continued From page 60 -The Administrator did not review a policy and she did not ask the Administrator what the proper procedure was to release medications with Resident #6's RP for the weekend. -The Administrator told her to make sure a medication release form was completed. -The Administrator did not give her any additional instructions. -She did not receive any formal training on management of controlled medications signed out for administration outside the facility. Interview with the Regional Director of Resident Care on 06/23/21 at 10:30am revealed: -She completed a controlled substance training with the MAs and MCM during their orientation on controlling the physical security of controlled substances on the medication cart and in the facility. -The training consisted of making sure they kept the controlled substances under close supervision, locked on the medication cart, reconciled with each shift MA at shift change, and reported missing controlled substances. -She did not provide the MAs and MCM any formal training on the release of controlled medications to be administered by a RP at home when a resident was on leave from the facility. Interview with the Administrator on 06/23/21 at 2:00pm revealed: -After Resident #6's RP contacted the facility on 06/18/21 to inform them the RP was taking Resident #6 home for a weekend visit she held a management meeting and instructed the MCM to make sure a medication release form was completed. -She did not review a policy with the management team at the time of the meeting because their policy was not specific to the release of	D 392		

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D 392	Continued From page 61 medications for residents leaving for overnight stays with their medications. -She expected the MAs and the MCM to complete the medication release form with the correct medication names, the complete physician order with instructions on the quantity and time for administration of the medications. -She expected when the medications were released and returned to the facility by the MAs or MCM the medications were counted, witnessed with two staff signatures, and then given to or accepted from the RP. -She learned today (06/23/21) the staff did not do what she expected them to do. -She failed to recognize the staff did not have an appropriate education of the formal process and now the Percocet could not be reconciled. -She reported the incident to the pharmacy, Health Care Personnel Registry and contacted the local police on 06/22/21.	D 392		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each	D 468		

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employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.
(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on interviews and record review the facility failed to ensure than that staff that worked in the Special Care Unit (SCU) had completed 12 hours of annual continuing education with 6 hours related to dementia specific care.

The findings are:

Review of employee record for Staff A, medication aide (MA) by the facility revealed:
-Staff A was hired on 07/22/19.
-He had 4.5 hours of dementia related continuing education training documented and a total of 9 hours of continuing education training documented since July 2020.

Interview with Staff A on 06/23/21 at 3:35 pm revealed:
-He worked at the facility since 2019.
-He received several dementia care trainings

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D 468	Continued From page 63 since working at the facility. -His most recent dementia care training was "two weeks ago". -He did not know how many SCU training hours he had completed. -He did not have certificates for any of the SCU training he completed. Interview with the Business Office Manager (BOM) on 06/23/21 at 3:40pm revealed: -She was responsible for maintaining personnel records for the facility. -She started working in July 2020 and completed an audit of all staff records in September 2020. -She reviewed Staff A's record, however thought he needed only 6 hours of SCU training. -She misunderstood Staff A needed a total of 26 SCU training hours. -She was trained by another BOM when she first started. -She used a checklist to confirm all staff had required trainings in their personnel record. Interview with the Administrator on 06/23/21 at 4:18pm revealed: -She was aware of the continuing education credits that Staff A needed to be a MA but was not aware of the annual continuing education hours required for the SCU. -The BOM was responsible for maintaining the staff records and tracking continuing education hours. -The Administrator audited records to ensure that the MA training was complete.	D 468		
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:	D912		

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D912	Continued From page 64 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 the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure staff assisted 3 of 5 sampled residents (#1, #4, & #5) including staff not providing catheter care (#1), and for two residents who required extensive assistance with bathing and dressing (#4 & #5).[Refer to Tag 0269 10 A NCAC 13F .0901(a) Personal Care and Supervision (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 observations, interviews, and record reviews, the facility failed to ensure all residents were free from neglect related to Health Care. Based on record reviews and interviews the	D914		

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D914	Continued From page 65 facility failed to meet the health care needs for 2 of 5 sampled residents (#1 & #4) by failing to follow up with monthly visits to the urologist for Foley catheter exchanges, not following up with a procedure to replace the Foley catheter with a suprapubic catheter, and not sending the resident to the emergency department (ED) when he requested to be evaluated for abdominal pain (#1) and coordinating a urologist visit for a resident with an elevated prostate-specific antigen (PSA)(#4).[Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D914		