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SOUTHERN LIVING FOR SENIORS OF BURNSVILLE N	270 LOVE FOX ROAD BURNSVILLE, NC 28714

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 03/16/22 - 03/17/22 with an exit conference via telephone on 03/17/22.	D 000		
D 176	10A NCAC 13F .0601 (a) Management Of Facilities 10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents (a) An adult care home administrator shall be responsible for the total operation of an adult care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the Administrator failed to ensure the overall management, operations, policies and procedures of the facility were implemented, maintained, and in substantial compliance with	D 176		

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D 176	Continued From page 1 the rules and statutes to meet and maintain rules related to management of a facility with a capacity or census of seven to thirty residents, resident rights including abuse, and Health Care Personnel Registry. The findings are: Observation of the facility on 03/16/22 at 8:37am revealed: -There was a State of North Carolina Department of Health and Human Services Division of Health Service Regulation Assisted Living Administrator document pinned to a bulletin board in the Facility Manager's office. -The named Administrator on the document was not in the facility. Interview with the Facility Manager on 03/16/22 at 10:45am revealed: -The named Administrator on the document on the wall in her office was not the current Administrator. -A new Administrator had been hired the week of February 14, 2022. -The new Administrator had not been in the facility although she had informed her she would. -She spoke to the Administrator about four times by telephone, but not in person. -Upper management had been attempting to hire an Administrator that lived closer to the facility because the new Administrator lived four hours away. -She was responsible for doing "everything" at the facility including personal care aide (PCA), Medication Aide (MA), Resident Care Coordinator (RCC), and Business Office Manager (BOM). -She would telephone the local Department of Social Services or the Chief Operating Officer (COO) for guidance.	D 176		

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-She was not qualified as an Administrator or Administrator-in-Charge (AIC).
-She received some training from a previous Administrator for 4 or 5 days.

Interview with the Medication Aide Supervisor (MA) on 03/16/22 at 8:30am revealed:
-The Facility Manager was the "main" management for the facility.
-The Facility Manager was the only person she would go to for any issues she encountered in the facility.
-The Facility Manager told her there was an Administrator that worked in a different city and she used her license for this facility.
-She had never met the Administrator and did not know her name.
-The Facility Manager needed more help because she was unable to do everything that needed to be accomplished in the facility.
-The Chief Operating Officer (COO) came to the facility about one day per month.

Interview with the MA Supervisor on 03/16/22 at 3:50pm revealed:
-She did not know how to reach the Administrator if she needed her assistance.
-She did not know the telephone number for the Administrator.
-She did not know the Administrator's last name.
-Sometimes it might take two or three attempts to get in contact with the Facility Manager.
-If she could not get in contact with the Facility Manager, she would just try and resolve the problem herself.

Interview with the Cook on 03/17/22 at 9:05am revealed:
-The owner and the COO were in charge of the facility.

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-She has never seen the owner in the facility.
-The COO was in the facility once per month for about 3 to 4 hours.
-When she had issues she would communicate them to the Facility Manager.
-She never communicated with the Administrator.
-She never saw the Administrator in the facility.

Interview with a personal care aide (PCA) on 03/17/22 at 9:25am revealed:
-The Facility Manager was the one that managed the facility.
-Sometimes it had been hard to determine who was "running" the facility.
-When he had issues he would communicate them to the MA Supervisor because the Facility Manager sometimes was not in the facility or too busy.
-He reported numerous times to the MA Supervisor and the Facility Manager that a staff verbally abused residents and nothing was done about and it continued for months.
-He spoke to the Administrator for the first time this morning (03/17/22) on the telephone.

Interview with the Facility Manager on 03/17/22 at 10:00am revealed:
-She had not informed the Administrator of the incidents of a staff verbally abusing residents because the Administrator was not involved in the daily operations of the facility.
-The Administrator was not in the facility and could not help much with anything.
-She had not suspended the staff or completed a Health Care Personnel Registry report within 24 hours of knowledge of staff verbally abusing residents because she had not known to do so (facility was cited on 02/18/22 for not reporting staff to HCPR due to allegations of abuse).
-She did not know if there was a policy and

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procedure for disciplinary actions of staff.
-She did not know the if Administrator was responsible for disciplinary actions or not.
-The Administrator had not offered her any guidance on anything.
-She would prefer to be the Resident Care Coordinator (RCC).
-She had not received much training for this position and was just "thrown into it".
-She taught herself her duties.
-She spoke with the owner once and he had informed her he would do what he could to help but nothing had been done.

Telephone interview with the Administrator on 03/16/22 at 10:15am revealed:
-She had been the Administrator for about three weeks.
-She had not been in the facility yet but was planning on being there in a few days because she lived four hours away.
-She was responsible for overseeing the facility, ensuring the residents were receiving care and the facility was up to standards.
-She spoke to the Facility Manager "a lot" and the Facility Manager kept her up to date on the facility issues.

Telephone interview with the Administrator on 03/16/22 at 1:43pm revealed:
-She spoke to a surveyor with the Adult Care Licensure Section (ACLS) after the previous survey (02/18/22) and had informed her she was no longer the Administrator.
-She then spoke to the facility Owner and agreed to continue to be the Administrator until the Owner could hire a permanent Administrator.
-She could not be at the facility frequently because she lived four hours away.

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Attempted telephone interview with the Administrator on 03/16/22 at 3:43pm revealed her voice mailbox was full and therefore a message was unable to be left.

Telephone interview with the Administrator on 03/16/22 at 6:49pm revealed:
-She was unable to be in the facility daily because she lived four hours away.
-She was a temporary Administrator until a permanent Administrator was hired.
-She was not aware an incident of abuse by staff had taken place.
-She was not aware the staff was still employed at the facility because there was a previous incident and the staff was supposed to be terminated.

Telephone interview with the facility Owner on 03/16/22 at 7:00pm revealed:
-There was an licensed Administrator for the facility.
-Locating an Administrator to work in the facility at that location was very difficult.
-He knew the Administrator was not working in the facility or had not been in the facility.
-He was responsible to hire an Administrator for the facility.
-He was aware that he needed to find an Administrator/AIC to be physically in the building to provide overall management of the facility and care for the residents.

Interview with the facility's contracted Nurse Consultant on 03/16/22 at 11:15am revealed:
-She was hired by the facility in October, 2021 to audit all staff and resident records and provide additional training to get all records back in compliance, observe staff during resident care, medication aides during medication

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administration, complete training related to any deficiencies cited during a previous survey, and provide staff resident rights training.
-She returned to the facility on 03/15/22, to check the progress and the staff required additional training on the same information as previously trained on in October, 2021.
-She had no contact by phone or in person with an Administrator.
-In October, 2021, after the audits, observations and interviews, she informed the Facility Manager and the Chief Operations Officer (COO) about all of the issues she found and of the additional training she needed to complete.
-On 03/15/22, after the audits, observations and interviews, she informed the Facility Manager and the COO about all of the issues she found and of the additional training she needed to completed that were mostly the same issues and training as in October 2021.
-The staff informed her that there was no oversite at the facility and everyone was doing there own version of the previous training or the new staff were trained by the staff present at the facility in October 2021.
-There was inconsistent documentation, staff were not familiar with policies and procedures, inadequate staffing, lack of training for PCAs and MAs, and this was not being corrected due to the lack of oversite by an Administrator in the building to make sure things were done correctly.
-During her audit on 03/15/22, she observed staff doing their job their way, not the way she trained them in October 2021.

Attempted telephone interview with the COO on 03/16/22 at 6:04pm was unsuccessful.

Non-compliance was identified at violation levels in the following areas:

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D 176	Continued From page 7 1. Based on interviews and record reviews, the facility failed to ensure there was an Administrator or Administrator in Charge (AIC) in the home or within 500 feet to ensure all residents were protected from physical and verbal abuse. [Refer to Tag D0177, 10A NCAC 13F .0601(b) Management of Facilities with a Capacity or Census of Seven to Thirty Residents (Type A2 Violation)]. 2. Based on interviews and record reviews the facility failed to ensure residents were protected from verbal and physical abuse related to staff (Staff B) yelling, cursing, treating residents with disrespect, communicating threats and physical abuse to residents (#4, #5, #6, and #7). [Refer to Tag D0338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)]. 3. Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry report within 24 hours of knowledge related to 1 staff member (Staff B) cursed and threatened residents (#4, #5, and #6) and displayed verbal and physical abuse to resident (#7). [Refer to Tag D0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A1 Violation)]. _____ The Administrator failed to ensure overall management and operations of the facility which compromised the care and safety of all residents to include not having an Administrator or an Administrator-in-Charge within 500 feet resulting in ongoing physical and verbal abuse related to staff threatening and bullying residents, leading them to fear retaliation by staff if they reported it and preventing residents from feeling safe to use the telephone or visit the living room and failing to	D 176		

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D 176	Continued From page 8 complete a Health Care Personnel Registry report within 24 hours of knowledge of this abuse. These failures resulted in serious neglect which constitutes an A1 Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 for this violation on 03/17/22. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 16, 2022	D 176		
D 177	10A NCAC 13F .0601 (b) Management Of Facilities With A Capacity Or 10A NCAC 13F .0601 Management Of Facilities With A Capacity Or Census Of Seven To Thirty Residents (b) At all times there shall be one administrator or administrator-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions in Paragraph (c) of this Rule, one of the following arrangements shall be used to manage a facility with a capacity or census of 7 to 30 residents: (1) The administrator is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; (2) An administrator-in-charge is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; or (3) When there is a cluster of licensed homes, each with a capacity of 7 to 12 residents, located adjacently on the same site, there shall be at	D 177		

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least one staff member, either live-in or on a shift basis in each of these homes. In addition, there shall be at least one administrator or administrator-in-charge who is within 500 feet of each home with a means of two-way telecommunication with each home at all times and directly responsible for assuring that all required duties are carried out in each home.

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

Based on interviews and record reviews, the facility failed to ensure there was an Administrator or Administrator in Charge (AIC) in the home or within 500 feet to ensure all residents were protected from physical and verbal abuse.

The findings are:

Review of the facility's current census upon entrance into the facility on 03/16/22 revealed there were 23 residents in the facility.

Review of the Facility Manager's personnel record revealed:
-She was hired 10/14/19 as the Resident Care Coordinator (RCC).
-There was documentation that she had completed high school.
-There was documentation that she had received training related to Medication Aide skills.
-There was no documentation that she had earned any continuing education credits related to managing an adult care home.

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D 177	Continued From page 10 Interview with Facility Manager on 03/16/22 at 10:45am and 1:33pm and on 03/17/22 at 10:00am revealed: -She had been the Facility Manager since July 2021. -She was over the age of 21. -She had previously been the RCC. -A previous Administrator trained her for 4 or 5 days. -The new Administrator had been the Administrator since the week of February 14, 2022. -The new Administrator had not been in the facility although she had informed her she would. -She spoke to the new Administrator about four times by telephone, but not in person. -Upper management had been attempting to hire an Administrator that lived closer to the facility because the new Administrator lived four hours away. -She was responsible for doing "everything" at the facility including personal care aide (PCA), Medication Aide (MA), Resident Care Coordinator (RCC), and Business Office Manager (BOM). -She would telephone the local Department of Social Services or the Chief Operating Officer (COO) for guidance because the new Administrator was not in the facility and could not help much with anything. -She was not an Administrator or Administrator-in-Charge (AIC) and had not taken any classes on management in a healthcare setting. -She had not informed the Administrator of the incidents of staff verbally and physically abusing residents because the Administrator was not involved in the daily operations of the facility. -She had not reported the abuse allegations to Health Care Personnel Registry (HCPR) within 24	D 177		

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hours because she had not known to do so (facility was cited on 02/18/22 for not reporting same staff to HCPR).
-The Administrator had not offered her any guidance.
-She would prefer to be the Resident Care Coordinator (RCC).
-She had not received much training for this position and was just "thrown into it".
-She taught herself her duties.
-She spoke with the owner once and he had informed her would do what he could to help but nothing had been done.

Interview with the Medication Aide Supervisor (MA) on 03/16/22 at 8:30am revealed:
-The Facility Manager was the "main" management for the facility.
-The Facility Manager was the only person she would go to for any issues she encountered in the facility.
-The Facility Manager told her there was an Administrator that worked in a different city and she used her license for this facility.
-She had never met the Administrator and did not know her name.
-The Facility Manager needed more help because she was unable to do everything that needed to be accomplished in the facility.
-The COO came to the facility about one day per month.

Interview with a personal care aide (PCA) on 03/17/22 at 9:25am revealed:
-The Facility Manager was the one that managed the facility.
-Sometimes it had been hard to determine who was "running" the facility.
-When he had issues he would communicate those to the MA Supervisor because the Facility

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Manager sometimes was not in the facility or too busy.
-He had reported numerous times to the MA Supervisor and the Facility Manager staff physically and verbally abused residents and nothing was done about and it continued for months.
-He spoke to the Administrator for the first this morning (03/17/22) on the telephone.

Interview with the facility's contracted Nurse Consultant on 03/16/22 at 11:15am revealed:
-She was hired by the facility in October 2021 to audit all staff and resident records and provide additional training to get all records back in compliance, observe staff during resident care, medication aides during medication administration, complete training related to any deficiencies cited during a previous survey, and provide staff resident rights training.
-She returned to the facility on 03/15/22, to check the progress and the staff required additional training on the same information as previously trained on in October, 2021.
-She had no contact by phone or in person with an Administrator.
-In October, 2021, after the audits, observations and interviews, she informed the Facility Manager and the Chief Operations Officer (COO) about all of the issues she found and of the additional training she needed to complete.
-On 03/15/22, after the audits, observations and interviews, she informed the Facility Manager and the COO about all of the issues she found and of the additional training she needed to completed that were mostly the same issues and training as in October 2021.
-The staff informed her that there was no oversite at the facility and everyone was doing there own version of the previous training or the new staff

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were trained by the staff present at the facility in October 2021.
-There was inconsistent documentation, staff were not familiar with policies and procedures, inadequate staffing, lack of training for PCAs and MAs, and this was not being corrected due to the lack of oversite by an Administrator in the building to make sure things were done correctly.
-During her audit on 03/15/22, she observed staff doing their job their way, not the way she trained them in October 2021.

Telephone interview with the Administrator on 03/16/22 at 10:15am revealed:
-She had been the Administrator for about three weeks.
-She had not been in the facility yet but was planning on being there in a few days because she lived four hours away.
-She was responsible for overseeing the facility, ensuring the residents were receiving care and the facility was up to standards.
-She spoke to the Facility Manager many times and the Facility Manager kept the her up to date on the facility issues.

Telephone interview with the Administrator on 03/16/22 at 1:43pm revealed:
-She spoke to a surveyor with the Adult Care Licensure Section (ACLS) after the previous survey (02/18/22) and had informed her she was no longer the Administrator.
-She then spoke to the facility Owner and agreed to continue to be the Administrator until the Owner could hire a permanent Administrator.
-She could not be at the facility frequently because she lived four hours away.

Attempted telephone interview with the Administrator on 03/16/22 at 3:43pm revealed her

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D 177	Continued From page 14 voice mailbox was full and therefore a message was unable to be left. Telephone interview with the Administrator on 03/16/22 at 6:49pm revealed: -She was unable to be in the facility daily because she lived four hours away. -She was the Administrator until a permanent Administrator was hired. -She was not aware more incidents of abuse with staff had taken place. -She was not aware the staff was still employed at the facility because there was a previous incident and the staff was supposed to be terminated. Attempted telephone interview with the COO on 03/16/22 at 6:04pm was unsuccessful. Telephone interview with the facility Owner on 03/16/22 at 7:00pm revealed: -There was a licensed Administrator for the facility who had not been in the facility since she was hired on 02/17/22. -Locating an Administrator to work in the facility at that location was very difficult. -He was aware that he needed to find an Administrator/AIC to be physically in the building to provide overall management of the facility and care for the residents. Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry _____ The facility failed to ensure there was an Administrator or Administrator-in-Charge in the facility to ensure all residents were protected from	D 177		

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D 177	Continued From page 15 physical and verbal abuse related to staff threatening and bullying residents. This failure resulted in residents continually being verbally and physically abused, threatened, and concerned for their own safety which was a serious risk to health, safety, and welfare of the residents and constitutes a Type A2 Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 for this violation on 03/17/22. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 16, 2022	D 177		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews the facility failed to ensure residents were protected from verbal and physical abuse related to staff (Staff B) yelling, cursing, treating residents with disrespect, communicating threats and physical abuse to residents (#4, #5, #6, and #7). The finding are: Review of Staff B's personnel file revealed Staff B was hired on 09/24/20 as a PCA.	D 338		

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1. Review of Resident #5's current FL2 dated 02/01/22 revealed:
-Diagnoses included hemiplegia, seizures, hypertension and personality disorder.
-He was non-ambulatory.

Review of Resident #5's Resident Register revealed an admission date of 02/01/22.

Review of Resident #5's Care Plan dated 02/15/22 revealed Resident #5 was total dependent on staff for ambulation, bathing, dressing, personal hygiene and transfers.

Interview with Resident #5 on 03/16/22 at 2:15pm revealed:
-He lived at the facility since January 2022.
-On 03/16/22, around 6:30am, Staff B roughly grabbed him by the shoulders from behind and forcefully turned him around and began cursing at him and accused him of stealing another person's cigarettes.
-Another staff told Staff B to "let go" of him or he would be fired.
-Staff B let him go and stated, to Resident #5, " I will break your jaw" so he would eat through a straw.
-He went to the front desk to use the resident phone to call for help and Staff B took the phone from him stating that Staff B did not give him permission.
-Staff B told him, he had a class on 03/15/22 on "how to treat residents" and that Staff B could "hit" him if he wanted to and that he did not have "rights" unless staff B said so.
-Staff B was controlling and a bully.
-Staff B cursed, threatened and physically abused him "just about on a daily basis".
-He would have reported the incident to the medication aide (MA) on shift at the time but he

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tried that before and nothing happened.
-In the past he reported threats from Staff B, such as Staff B was going to put him in the hospital and break his jaw to the Facility Manager and nothing was done.
-He also reported other issues with Staff B to other staff and was told to record issues on his phone.
-About 2 weeks ago, he recorded an incident related to not receiving his medications, and Staff B threatened to put him in the hospital if he did not give Staff B his cell phone.
-All night long, Staff B tried to take his cell phone away from him using threats and attempts to steal the phone.
-About 2 weeks ago, he saw another resident stand up out of his wheelchair to sit on the sofa in the community living room and Staff B forced another resident by his shoulders back down into the wheelchair while Staff B stated, he did not give him permission to get out of his wheelchair.
-He told Staff B that the cameras would record his behaviors and Staff B informed him that he "took care" of the cameras.
-His concern now was there was no way to prove to law enforcement what was going on because staff B "took care" of the cameras and no one at the facility would do anything about Staff B.
-Staff B liked to pick on residents who were in wheelchairs who were harder to defend themselves.
-He felt Staff B was dangerous and he felt threatened, unsafe and afraid and now carries a "sock of rocks" to defend himself.

Interview with a personal care aide (PCA) on 03/16/22 at 4:01pm revealed:
-About 2 weeks ago Resident #5 reported to him that Staff B threatened to put him in the hospital because Resident #5 recorded a MA and was

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trying to steal his phone.
-He reported the incident to the MA Supervisor and they went to the Facility Manager and nothing was done to Staff B.
-Staff B treated certain residents worse after he reported to the Facility Manager.
-Resident #5 now carries a sock filled with rocks with him at all times for protection.

Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm.

Refer to the interview with the Cook on 03/17/22 at 9:05am.

Refer to the interview with a personal care aide PCA) on 03/17/22 at 9:25am.

Refer to the interview with the Facility Manager on 03/17/22 at 10:00am.

Refer to the telephone interview with the Administrator on 03/17/22 at 10:54am.

2. Review of Resident #6's current FL2 dated 01/24/22 revealed:
-Diagnoses included schizoaffective disorder.
-He was ambulatory.

Review of Resident #6's Resident Register revealed an admission date of 01/24/22.

Review of Resident #6's Care Plan dated 02/01/22 revealed Resident #6 was independent with activities of daily living.

Interview with Resident #6 on 03/16/22 at 3:23pm revealed:
-On 03/16/22, around 6:30am, Staff B was yelling and cursing at him because he wanted to know

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why he could not have a sandwich last night.
-On 03/15/22, he asked for a sandwich after the evening meal because he was still hungry and staff B told him he could not have any more food.
-The only answer Staff B gave him was because Staff B "said so" and Staff B "was in charge".
-He just wanted to know why other than because Staff B "said so" and Staff B began yelling and cursing at him and threatened to "knock him to the floor", so he dropped it.
-Staff B was rude to him often but that was the first time he was threatened by Staff B.
-He did not tell anyone because there were other staff there and thought they would handle it.
-He stays in his room when Staff B was working, because he did not want to be kicked out of his home.

Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm.

Refer to the interview with the Cook on 03/17/22 at 9:05am.

Refer to the interview with a personal care aide (PCA) on 03/17/22 at 9:25am.

Refer to the interview with the Facility Manager on 03/17/22 at 10:00am.

Refer to the telephone interview with the Administrator on 03/17/22 at 10:54am.

3. Review of Resident #7's current FL2 dated 02/22/22 revealed:
-Diagnoses included depression, anxiety, chronic pulmonary disease, and muscle weakness.
-He was semi-ambulatory.
-He required a wheelchair.

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Review of Resident #7's Resident Register revealed an admission date of 07/17/19.

Review of Resident #7's Care Plan dated 02/01/22 revealed Resident #7 required limited assistance with toileting, ambulation, bathing, dressing, personal hygiene and transfers.

Interview with Resident #7 on 03/16/22 at 3:30pm revealed:
-In the past 3 weeks, Staff B was mean to him and hurt him.
-The first incident within the past 3 weeks was when he tried to go down the hall to the living room in his wheelchair and Staff B yelled at him and then stopped him by coming up from behind him and lifting his front wheels to his wheel chair up off of the ground and tilting him back in his wheelchair.
-He told Staff B to stop and Staff B said that he "did not" give him permission to go to the living room.
-He did not think he needed permission to go to the living room.
-The second incident in the past 3 weeks was when Staff B prevented him from getting out of his wheelchair to sit on the sofa by forcing him back into his wheelchair by his shoulder when he stood up.
-When Staff B forced him back down into the wheelchair, it hurt his shoulders.
-He informed the day shift MA, but Staff B continued to work there, and he was afraid Staff B would come back after he reported it and hurt him bad because Staff B was mean and he was scared of him.

Interview with another resident on 03/16/22 at 3:47pm revealed:
-About 2 weeks ago he saw Staff B stop Resident

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#7 from going to use the phone by tilting Resident #7's wheelchair back, and telling he he could no go because Staff B did not give him permission.
-About 2 weeks ago there was also a second time when Staff B stopped Resident #7 from getting out of his wheelchair by forcing Resident #7 back into his wheelchair which hurt Resident #7.
-He and other residents reported Staff B's abuse to the Facility Manager but nothing was done to Staff B and Staff B still worked at the facility and he was fearful all the time from retribution from Staff B.

Interview with a MA Supervisor on 03/16/22 at 3:36pm revealed:
-About 2 weeks ago a resident reported an incident between Staff B and Resident #7.
-She asked Resident #7 if there was an issue with Staff B.
-Resident #7 told her about Staff B forcefully pushing his shoulders and sitting Resident #7 back into his wheelchair because Staff B was controlling him.
-She informed the Facility Manager but was told there was not enough staff to work if Staff B was terminated they would be left short staffed.

Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm.

Refer to the interview with the Cook on 03/17/22 at 9:05am.

Refer to the interview with a personal care aide (PCA) on 03/17/22 at 9:25am.

Refer to the interview with the Facility Manager on 03/17/22 at 10:00am.

Refer to the telephone interview with the

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Administrator on 03/17/22 at 10:54am.

4. Review of Resident #4's current FL2 dated 02/15/22 revealed:
-Diagnoses included anxiety disorder and depression.
-The resident was non-ambulatory and used an electric wheelchair.

Review of Resident #4's care plan dated 02/22/22 revealed the resident needed extensive assistance with transfers.

Interview with Resident #4 on 03/17/22 at 2:15pm revealed:
-He ambulated with his wheelchair on the evening of 2/18/22 to the front office to get assistance transferring to his bed.
-Staff B and the Facility Manager were at the front office and Staff B and the resident started to argue.
-Staff B told him, he was an "old man and a liar".
-Staff B was yelling and cursing at the him.
-The Facility Manager instructed the him to go back to his room.
-Staff B talks to most of the residents in the same manner and staff knows about it because they have all heard it.
-During another incident Staff B positioned his chin forward to him and stated "go ahead and hit me".
-During another incident Staff B opened the front door and instructed him to go outside so they could fight but the resident did not go outside.

Interview with a medication aide (MA) on 03/16/22 at 2:30pm revealed:
-She worked in the facility from 7:00pm to 7:00am.
-On the evening of 02/18/22 she had heard loud

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voices yelling and cursing in the facility.
-She heard Staff B and Resident #4 yelling and cursing at each other near the front office.
-She heard Staff B say to Resident #4 "at least I have legs and walk, you are in a wheelchair and can't, you are half a man".
-She heard the Facility Manager instruct Staff B to sit down in her office.
-She thought Resident #4 would deny the incident for fear of retribution from Staff B.

Interview with the Facility Manager on 03/17/22 at 1:15pm revealed:
-She was in her office on 02/18/22 at approximately 6:30pm when Resident #4 came to her door and asked if staff could assist him into bed.
-She had informed Resident #4, it would be a couple of minutes and then staff would be down to his room to assist him.
-Staff B just came into work and entered her office when the resident came back to her office and started yelling at Staff B.
-She attempted to calm Resident #4 down but he just kept yelling at Staff B.
-Staff B raised his voice and cursed at the resident.
-She could not remember what Staff B said to the resident but she knew it was verbally abusive.
-This exchange went on for 5 to 10 minutes.
-She told Staff B to go sit in her office.
-She did not suspend or terminated Staff B because she did not know what to do or supposed to do.
-She was new to her position and had not thought or known to call and report the incident to upper management.

Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm.

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D 338	Continued From page 24 Refer to the interview with the Cook on 03/17/22 at 9:05am. Refer to the interview with a personal care aide (PCA) on 03/17/22 at 9:25am. Refer to the interview with the Facility Manager on 03/17/22 at 10:00am. Refer to the telephone interview with the Administrator on 03/17/22 at 10:54am. _____ Interview with the MA Supervisor on 03/16/22 at 3:25pm revealed: -She received complaints from residents that Staff B had been verbally aggressive and threatened to physically harm them. -She reported these complaints to the facility manager but no action had been taken that she knew of. -She did not have the authority to terminate Staff B and instructed the residents to record any incident with their telephones. -She informed the Chief Operating Officer (COO) in February 2022 that Staff B should be terminated for his behavior and his response was he thought the facility manager had already terminated Staff B. Interview with the Cook on 03/17/22 at 9:05am revealed: -She heard Staff B being verbally abusive to the residents in the facility. -The residents knew how to "push his buttons" and then Staff B would raise his voice and curse at the residents. -The MA Supervisor and the facility manager had been witness to the incidents so she had no need to report it.	D 338		

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D 338	Continued From page 25 -She knew it was not appropriate to speak to the residents in that manner, even if they "pushed his buttons". -She received Resident Rights training on 03/15/22. Interview with a personal care aide (PCA) on 03/17/22 at 9:25am revealed: -He witnessed Staff B verbally abuse residents 6 or 7 times in the past year. -Staff B had "bragged" about verbally abusing the residents. -He reported these incidents to the MA Supervisor and to the facility manager but did not know what action had been taken. -The residents were fearful of Staff B. -He documented in the resident record about these incidents but the pages would "disappear". -He received Resident Rights training on 03/15/22. Interview with the Facility Manager on 03/17/22 at 10:00am revealed: -Staff B was terminated more than one year earlier due to poor work performance and rehired due to the facility being short staffed. -There was an allegation against Staff B of abuse in December 2021 and the local Department of Social Services initiated an investigation but she did not know the outcome. -Both residents and staff reported to her that Staff B continued to verbally abuse residents. -She would "just" question Staff B on the incidents. -The incidents of verbal abuse were usually just "little arguments" between Staff B and a resident. -She did not know that she should have suspended Staff B and conducted an investigation, (facility was cited on 02/18/22 for not reporting Staff B to HCPR due to allegations	D 338		

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of abuse).
-She had not reported it to the Administrator because the Administrator was not involved in the daily operations of the facility.
-She did not know why she did not reported it to the COO.
-She did not know if there was a policy and procedure related to employee disciplinary action.

Telephone interview with the Administrator on 03/17/22 at 10:54am revealed:
-She was not aware of the allegations of abuse by Staff B, (facility was cited on 02/18/22 for not reporting staff to HCPR due to allegations of abuse).
-Staff should have notified her of the allegations.
-She did not know if the Facility Manager had received training on 24 hour and 5 day reporting and investigations or not.
-She was responsible for for ensuring staff received the training.

Attempted telephone interview with a third shift MA on 03/17/22 at 10:40am was unsuccessful.

Attempted telephone interview with Staff B on 03/17/22 at 10:40am was unsuccessful.

Attempted communication via text message with Staff B on 03/17/22 at 10:41am was unsuccessful.

Requested resident progress noted but not received prior to exit on 03/17/22.

The facility failed to ensure residents were free of verbal abuse and treated with respect and dignity related to a staff (Staff B) yelling, cursing and threatened (Resident #4), yelling, cursing, threatened to break the jaw and put a resident in

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SOUTHERN LIVING FOR SENIORS OF BURNSVILLE N	270 LOVE FOX ROAD BURNSVILLE, NC 28714

(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 338	Continued From page 27 the hospital causing fear of retaliation from Staff B and the need to carry a sock full of rocks to protect himself (Resident #5), yelling and threatened physical harm for asking a question (Resident #6), yelling, causing physical harm, and bullying (Resident #7). This failure resulted in residents being verbally abused, threatened, bullied, and fearful of retaliation and concern for their safety which resulted in serious risk to the health, safety and welfare of the residents and constitutes a Type A2 Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 for this violation on 03/17/22. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 16, 2022.	D 338		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry report within 24 hours of knowledge related to 1 staff member (Staff B) cursed and threatened residents (#4, #5, and #6) and displayed verbal and physical abuse to	D 438		

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resident (#7).

The findings are:

Review of Staff B's, Personal Care Aide (PCA), personnel file revealed:
-Date of hire: 09/23/20.
-Staff B's position title was Personal Care Aide.
-There was an HCPR dated 09/23/20 with no substantial findings.
-There was no HCPR completed prior to exit on 03/18/22.

Review of the facility's records revealed there was no 24-hour or 5-day report to HCPR.

1. Review of Staff B's time card reports dated 02/18/22 reveled Staff B worked from 6:38pm until 8:16am on 02/19/22.

Interview with a medication aide (MA) on 03/16/22 at 2:30pm revealed:
-She worked in the facility from 7:00pm to 7:00am.
-On the evening of 02/18/22 she heard loud voices yelling and cursing in the facility.
-She heard Staff B and Resident #4 yelling and cursing at each other near the front office.
-She heard Staff B say to Resident #4 "at least I have legs and walk, you are in a wheelchair and can't, you are half a man".
-She heard the Facility Manager instruct Staff B to sit down in her office.
-She thought Resident #4 would deny the incident for fear of retribution from Staff B.

Interview with Resident #4 on 03/17/22 at 2:15pm revealed:
-He ambulated with his wheelchair on the evening of 2/18/22 to the front office to get assistance

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transferring to his bed.
-Staff B and the Facility Manager were at the front office when Staff B started to argue with him.
-Staff B told the him he was an "old man and a liar".
-Staff B was yelling and cursing at the him.
-The Facility Manager instructed him to go back to his room.
-Staff B spoke to most of the residents in the same manner and staff knew about it because they all heard it.
-During another incident Staff B positioned his chin forward to him and stated "go ahead and hit me".
-During another incident Staff B opened the front door and instructed the resident to go outside so they could fight but the resident did not go outside.
-He felt that Staff B should not work in any environment caring for residents.

Interview with the Facility Manager on 03/16/22 at 10:45am and 1:33pm and on 03/17/22 at 10:00am revealed:
-She was not qualified as an Administrator and Administrator-in-Charge (AIC).
-She had not informed the Administrator of the incident of Staff B verbally and physically abusing residents because the Administrator was not involved in the daily operations of the facility.
-She had not reported the abuse allegations to Health Care Personnel Registry within 24 hours because she had not known to do so(facility was cited on 02/18/22 for not reporting Staff B to HCPR due to allegations of abuse).
-The Administrator was not in the facility and could not help much with anything.

Interview with the Facility Manager on 03/17/22 at 1:15pm revealed:

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-On 02/18/22, Resident #4 came to her door and asked if staff could assist him into bed.
-She informed Resident #4 it would be a couple of minutes and then staff would be down to his room to assist him.
-Staff B just came to work and entered her office when the Resident #4 came back to her office and started yelling at Staff B.
-She attempted to calm Resident #4 down but he just kept yelling at Staff B.
-Staff B raised his voice and cursed at the resident.
-She could not remember what Staff B said to the resident but she knew it was verbally abusive.
-This exchange went on for 5 to 10 minutes.
-She told Staff B to go sit in her office.
-She did not suspend or terminated Staff B because she did not know what to do or supposed to do.
-She was new to her position and had not thought or known to call and report the incident to upper management.

Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm.

Refer to the interview with the Cook on 03/17/22 at 9:05am.

Refer to the interview with a personal care aide (PCA) on 03/17/22 at 9:25am.

Refer to the interview with the Facility Manager on 03/17/22 at 10:00am.

Refer to the telephone interview with the Administrator on 03/17/22 at 10:54am.

2. Review of Staff B's time card reports dated 03/15/22 reveled Staff B worked from 5:24pm

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D 438	Continued From page 31 until 6:42am on 03/16/22. Interview with Resident #5 on 03/16/22 at 2:15pm revealed: -He lived at the facility since January 2022. -On 03/16/22, around 6:30am, Staff B roughly grabbed him by the shoulders from behind and forcefully turned him around and began cursing at him and accused him of stealing another person's cigarettes. -Another staff told Staff B to "let go" of him or Staff B would be fired. -Staff B let him go and stated, " I will break your jaw" so he would eat through a straw. -He went to the front desk to use the resident phone to call for help and Staff B took the phone from him stating that Staff B did not give him permission. -Staff B told him, he had a class on 03/15/22 on "how to treat residents" and that Staff B could "hit" him if he wanted to and that he did not have "rights" unless staff B said so. -He felt Staff B was controlling and a bully. -He felt Staff B cursed, threatened and physically abused him "just about on a daily basis". -He felt Staff B was dangerous and he felt threatened, unsafe and afraid and now carries a "sock of rocks" to defend himself. Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm. Refer to the interview with the Cook on 03/17/22 at 9:05am. Refer to the interview with a personal care aide (PCA) on 03/17/22 at 9:25am. Refer to the interview with the Facility Manager on 03/17/22 at 10:00am.	D 438		

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D 438	Continued From page 32 Refer to the telephone interview with the Administrator on 03/17/22 at 10:54am. 3. Interview with Resident #6 on 03/16/22 at 3:23pm revealed: -On 03/16/22, around 6:30am, Staff B was yelling and cursing at him because he wanted to know why he could not have a sandwich last night. -On 03/15/22, he asked for a sandwich after the evening meal because he was still hungry and staff B told him he could not have any more food. -The only answer Staff B gave him was because Staff B "said so" and Staff B "was in charge". -He just wanted to know why other than because Staff B "said so" and Staff B began yelling and cursing at him and threatened to "knock him to the floor", so he dropped it. Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm. Refer to the interview with the Cook on 03/17/22 at 9:05am. Refer to the interview with a personal care aide (PCA) on 03/17/22 at 9:25am. Refer to the interview with the Facility Manager on 03/17/22 at 10:00am. Refer to the telephone interview with the Administrator on 03/17/22 at 10:54am. 4. Interview with Resident #7 on 03/16/22 at 3:30pm revealed: -In the past 3 weeks, Staff B was mean to him and hurt him. -The first incident within the past 3 weeks was when he tried to go down the hall to the living	D 438		

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room in his wheelchair and Staff B yelled at him and then stopped him by coming up from behind him and lifting his front wheels to his wheelchair up off of the ground and tilting him back in his wheelchair.
-He told Staff B to stop and Staff B said that he "did not" give him permission to go to the living room.
-He did not think he needed permission to go to the living room.
-The second incident in the past 3 weeks was when Staff B prevented him from getting out of his wheelchair to sit on the sofa by forcing him back into his wheelchair by his shoulder when he stood up.
-When Staff B forced him back down into the wheelchair, it hurt his shoulders.
-He did inform the day shift MA, but Staff B still works there, and he was afraid Staff B would come back after he reported it and hurt him bad because Staff B was mean and he was scared of him.

Refer to the interview with the MA Supervisor on 03/16/22 at 3:25pm.

Refer to the interview with the Cook on 03/17/22 at 9:05am.

Refer to the interview with a personal care aide (PCA) on 03/17/22 at 9:25am.

Refer to the interview with the Facility Manager on 03/17/22 at 10:00am.

Refer to the telephone interview with the Administrator on 03/17/22 at 10:54am.

_____

Interview with the MA Supervisor on 03/16/22 at 3:25pm revealed:

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-She received complaints from residents that Staff B had been verbally aggressive and threatened to physically harm them.
-She reported these complaints to the facility manager several times over the past three weeks but no action had been taken that she knew of.
-The facility manager informed her, if the facility manager fired Staff B, the facility would be short staffed.
-She informed the Chief Operating Officer (COO) in February 2022 that Staff B should be terminated for his behavior and his response was he thought the facility manager had already terminated Staff B.

Interview with the Cook on 03/17/22 at 9:05am revealed:
-She heard Staff B being verbally abusive to the residents in the facility.
-The MA Supervisor and the facility manager had been witness to the incidents so she had no need to report it.

Interview with a personal care aide (PCA) on 03/17/22 at 9:25am revealed:
-He witnessed Staff B's verbal abuse to residents at least 6 or 7 times in the past year.
-Staff B "bragged" about verbally abusing the residents.
-He reported these incidents to the MA Supervisor and to the facility manager but did not know what action had been taken.
-He believed the residents were fearful of Staff B.

Interview with the Facility Manager on 03/17/22 at 10:00am revealed:
-Staff B had been terminated more than one year earlier due to poor work performance and rehired due to the facility being short staffed.
-There had been an allegation against Staff B of

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abuse in December 2021 and the local Department of Social Services had initiated an investigation but she did not know the outcome.
-Both residents and staff had reported to her that Staff B continued to verbally abuse residents.
-She questioned Staff B on the incidents.
-The incidents of verbal abuse were usually just "little arguments" between Staff B and a resident.
-She did not know that she should have suspended Staff B and conducted an investigation, (facility was cited on 02/18/22 for not reporting Staff B to HCPR due to allegations of abuse).
-She had not reported the incidents to the Administrator because the Administrator was not involved in the daily operations of the facility.
-She did not report the incidents to the COO and did not know why.
-She did not know if there was a policy and procedure related to employee disciplinary action.

Telephone interview with the Administrator on 03/17/22 at 10:54am revealed:
-She was not aware of the allegations of abuse by Staff B, (facility was cited on 02/18/22 for not reporting staff to HCPR due to allegations of abuse).
-Staff should have notified her of the allegations.
-She did not know if the Facility Manager had received training on 24 hour and 5 day reporting and investigations or not.

Attempted telephone interview with a third shift MA on 03/17/22 at 10:40am was unsuccessful.

Attempted telephone interview with Staff B on 03/17/22 at 10:40am was unsuccessful.

Attempted communication via text message with Staff B on 03/17/22 at 10:41am was

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D 438	Continued From page 36 unsuccessful. _____ The facility failed to ensure allegations of verbal and physical abuse was reported to the HCPR resulting in Staff B continuing to work with residents and continued to yell, curse and threaten (Resident #4), yell, curse, threaten to break the jaw and put a resident in the hospital causing fear of retaliation from Staff B and for him, the need to carry a sock full of rocks to protect himself (Resident #5), yell and threaten physical harm for asking a question (Resident #6), yell, and caused physical harm by Staff B (Resident #7). This failure resulted in residents being verbally abused, threatened, bullied and fearful of retaliation and concern for their safety which resulted in serious neglect to the health, safety and welfare of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/17/22. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 16, 2022.	D 438		
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:	D914		

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D914	Continued From page 37 Based on observation, interviews and record reviews the facility failed to ensure residents were free from abuse related to not having an Administrator or Administrator-in-Charge within 500 feet of the facility, not providing the overall management of the facility, resident rights including abuse, and not completing within 24 hours of knowledge of abuse a Health Care Personnel Registry report. 1. Based on observations, interviews and record reviews, the Administrator failed to ensure the overall management, operations, policies and procedures of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to management of a facility with a capacity or census of seven to thirty residents, resident rights including abuse, and health care personnel registry. [Refer to Tag D0176, 10A NCAC 13F .0601(a) Management of Facilities (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure there was an Administrator or Administrator in Charge (AIC) in the home or within 500 feet to ensure all residents were protected from physical and verbal abuse. [Refer to Tag D0177, 10A NCAC 13F .0601(b) Management of Facilities with a Capacity or Census of Seven to Thirty Residents (Type A2 Violation)]. 3. Based on interviews and record reviews the facility failed to ensure residents were protected from verbal and physical abuse related to staff (Staff B) yelling, cursing, treating residents with disrespect, communicating threats and physical abuse to residents (#4, #5, #6, and #7). [Refer to Tag D0338, 10A NCAC 13F .0909 Resident	D914		

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D914	Continued From page 38 Rights (Type A2 Violation)]. 4. Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry report within 24 hours of knowledge related to 1 staff member (Staff B) cursed and threatened residents (#4, #5, and #6) and displayed verbal and physical abuse to resident (#7). [Refer to Tag D0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A1 Violation)].	D914		